

TOWARD A SYSTEMATIC CLINICAL PSYCHOLOGY:  
An Inquiry Into Some Problems And Issues

by

Jerome Schiffer  
B.A., New York University, 1936

Submitted to the Department of  
Psychology and the Faculty of  
the Graduate School of the Uni-  
versity of Kansas in partial  
filfillment of the requirements  
for the degree of Doctor of  
Philosophy.

Advisory Committee:

Beulah M. Morrison

Chairman

R. Ness Haagen

C. P. Osborne

June, 1947

To my wife Louise, and son, Danny.



## ACKNOWLEDGMENTS

I particularly wish to express my gratitude to Miss Beulah M. Morrison, Professor of Psychology, for her constant, invaluable assistance and encouragement. Professor C. Hess Haagen gave many constructive criticisms and suggestions, and the other faculty members of the Department of Psychology were always willing to discuss the questions I might bring to them. The discussions I had with my fellow students in the Department were not only enjoyable but helpful.

Professor E. H. Hollands of the Philosophy Department advised me on several aspects of the study, and Professor C. P. Osborne of the Philosophy Department helped especially with the material on Ethics.

I discussed aspects of this study with many other people too numerous to name, but I should like to mention Professor A. H. Turney of the School of Education, and Dr. R. C. Challman of the Winter Veterans Hospital. Miss Dorothy Haglund, Secretary to the Dean of the Graduate School, was extremely kind in consenting to type the manuscript.

J.S.

# TABLE OF CONTENTS

CHAPTER	PAGE
INTRODUCTION . . . . .	1
Background . . . . .	1
The Method of Inquiry . . . . .	iii
Justification and Further Description of the Method . . .	vi
I. GENERAL STATUS OF CLINICAL PSYCHOLOGY (1947) . . . . .	1
Part I	
Signs of Growth . . . . .	2
The Issue of Charlatanism . . . . .	8
Relationships to Allied Professions- especially Psychiatry . . . . .	12
Some Aspects of the Present Problem of Professional Relationships to Psychiatry . . . . .	16
Part II	
The Areas in which Clinical Psychology Functions . . . . .	24
The Armed Services: World War I . . . . .	25
The Armed Services: World War II . . . . .	27
Rehabilitation of Veterans . . . . .	35
Clinical Psychology in Hospitals . . . . .	38
Clinical Psychology in Industry . . . . .	45
Clinical Psychology in Guidance and Counseling . . . . .	50
Clinical Psychology in Relation to Delinquency and Crime . . . . .	56

II. SOME BASIC PROBLEMS REGARDING SCIENCE AS RELATED TO THE DEFINITION OF CLINICAL PSYCHOLOGY . . . . .	60
General Plan of Chapter . . . . .	60
Recent Trends Toward a General Definition of Science: Some Ideas of Rudolf Carnap and John Dewey . . . . .	61
The Ideas of C. W. Morris on the General Definition of Science .	66
The Non-scientific Realms of Dis- course as Analysed by C. W. Morris and Their Relation to Clinical Psychology . . . . .	70
The Issue of Quantifiability as a Requirement of Science . . . . .	75
The Problem of the Distinction between Natural and Social Science--The Position of F. H. Knight . . . . .	77
The Views of Otto Neurath Relative to the Distinction between Natural and Social Science . .	82
The Views of W. B. Donham Relative to the Distinction between Natural and Social Science . .	86
Further Considerations Regarding the Distinction between Natural and Social Science-- The Position of S. Hook . . . . .	88
The Outcome for Clinical Psychology.	91
Applied Science as Related to the Definition of Clinical Psychology . . . . .	96
The Problem of Rapprochement of Pure and Applied Science . . . . .	102

III.	SOME BASIC PROBLEMS REGARDING ART AS RELATED TO THE DEFINITION OF CLINICAL PSYCHOLOGY . . . . .	109
	General Plan of Chapter . . . . .	109
	The Issue of the Single Case . . . . .	110
	The Issue of the Single Case as Related to the Nomothetic- Idiographic Issue . . . . .	118
	The Issue of the Single Case in Relation to the Problem of Prediction . . . . .	125
	The Issue of the Psychometric Versus the Clinical Approach . . . . .	137
	The Psychometric Versus the Clinical Issue with Special Reference to Diagnostic Test- ing and Projective Techniques . . . . .	145
	The Meaning of "Clinical" in the Definition of Clinical Psychology . . . . .	156
IV.	CLINICAL PSYCHOLOGY AS A PROFESSION; THE ETHICS OF CLINICAL PSYCHOLOGY . . . . .	165
	General Plan of Chapter . . . . .	165
	The Meaning and Significance of Ethics in Relation to Clinical Psychology . . . . .	166
	The Concept of Profession . . . . .	173
	Suggestions on the Problem of Standards of Professional Achievement and Competence . . . . .	192
	Problems of Training . . . . .	198
	The Issue of Certification and Licensing . . . . .	207

## CHAPTER

PAGE

V.	SOME PROBLEMS IN PSYCHOTHERAPY AND PSYCHIATRY AS RELATED TO CLINICAL PSYCHOLOGY . . . . .	212
	General Plan of Chapter . . . . .	212
	Brief Sketch of Present Character of Psychiatry . . . . .	214
	The Psychoanalytic School of Psychotherapy . . . . .	220
	Hypnoanalysis and Narcosynthesis. .	228
	Horney's "New Ways" in Psycho- analysis . . . . .	233
	Nondirective or Client-Centered Psychotherapy . . . . .	238
	The Meaning of Psychotherapy from the Viewpoint of Clinical Psychology . . . . .	248
	CONCLUDING STATEMENT . . . . .	253
	BIBLIOGRAPHY . . . . .	260

## INTRODUCTION

### 1. Background.

The background of this thesis is varied and complex. From the point of view of the subject matter and content, it will be seen that the thesis cuts across a variety of disciplines as they have been conventionally defined. This circumstance arises directly out of the very nature of clinical psychology, the complexities of which should become more apparent as the study progresses.

From the viewpoint of the immediate orientation of the writer, the background also appears variegated. Practical experience and contacts in the field of clinical psychology cannot have failed to impress one with the amorphous and anomalous appearance presented by clinical psychology as a discipline. Academic and philosophical interests prompted the belief that the amorphous and anomalous appearance of clinical psychology offers many challenging problems and issues which demand critical examination and inquiry. Such an inquiry should provide the basis for understanding the reasons behind the amorphous and anomalous appearance of clinical psychology and to discover whether it is merely illusory, or whether it is an inevitable reflection of the inherently complex nature of clinical psychology. Such an inquiry should also provide the basis for arriving at a clearer formulation of

clinical psychology which would dispel a certain amount of the present disconcerting appearance. This should be the case even though the inherent complexities of content might inevitably cause clinical psychology to appear amorphous to some extent.

In a sense, however, the present study must be founded upon the assumption that the amorphous and anomalous appearance of clinical psychology is illusory. The presumption is that clinical psychology has recognizable and discernable characteristics and attributes which may be interrelated in a more or less consistent manner. In more objective terms, the underlying assumption of this study is that clinical psychology represents an integrated body of knowledge from the point of view of theories and facts, as well as methods, aims, and objectives.

This assumption may be called the working hypothesis upon which the study proceeds. It implies that the theories, facts, methods, aims and objectives of clinical psychology are systematically related in discernable ways and to an extent necessary to constitute a generic discipline. It is in a very literal sense that the terms assumption and hypothesis are intended, however. For, clinical psychology does not readily present itself in any clearly seen systematic manner, much less in any single, universally accepted fashion. It is precisely for this reason that the method chosen to carry out this

study is the method of inquiry. This method involves only the very general supposition that clinical psychology represents a generic discipline. It places a distinct emphasis upon the searching out of possible patterns of relationship and organization and must assume the possible existence of such patterns of relationship, but no further assumptions are necessary regarding the actual details of how clinical psychology may be organized. It does not start out with any preconceptions, at least the attempt is to start out with as few as possible and to make these explicit wherever this may be done.

## 2. The Method Of Inquiry

The method of inquiry chosen to investigate the possible existence of order and organization in clinical psychology may now be described in somewhat more detail. In the first place, the method involves an exploratory search to ascertain what are some of the problems and issues inherent in clinical psychology which seem to block a systematic formulation. Following, or coincidentally with such discovery of the problems, the method involves the statement of them in as clear a manner as possible. For, while the problems are numerous and vexing, they are in many instances but dimly perceived, and consequently rarely stated with any clarity if they are stated at all.

Further, the method of inquiry consists of



attempting to uncover and investigate some of the possible interrelationships existing among the various problems and issues. In general, the discovery of interrelationships coincidentally requires a certain amount of reflective analysis which may also take on the character of a critical analysis wherever this seems warranted by the subject matter. Critical evaluations and judgments will sometimes be offered and some attempt will be made to evaluate the importance and significance of the problems and issues in relation to clinical psychology in general. In most cases, however, considerations relative to the subject matter and content of the material under immediate discussion will be allowed to influence, if not control, the reflective analysis and the forming of critical evaluations and judgments.

This means, then, that the method of inquiry does not proceed on any dogmatic basis. Clinical psychology, it is felt, represents a recently emerged, in fact a still emerging, area which cannot be adequately understood or appreciated in terms of rigidly conceived dogmatic principles. Such an area cannot be fully if at all illuminated when approached from a rigid standpoint. The emergent character of clinical psychology is likely to render any sort of dogmatism fruitless and fatally inflexible in the face of unknown and unpredictable developments. The application of dogmatic principles for the purpose of understanding,

clarifying, and critically evaluating the problems and issues inherent in clinical psychology today must be avoided, even though such a procedure might offer a certain amount of intellectual security, and allow clinical psychology to appear more stable. Such an aspect of stability could be attained only at the cost of rendering clinical psychology sterile.

While the method of inquiry cannot proceed on a dogmatic basis, neither can it proceed satisfactorily by eschewing principles entirely. Some orientation is obviously necessary, some hypotheses must be formulated, some principles must be employed to guide the inquiry. The general working hypothesis has already been indicated, namely, that clinical psychology is a generic discipline. Other assumptions related to specific problems will have to be made in order to guide the inquiry, and as already indicated, will be made as explicit as possible.

Incidentally, it is well to point out in this connection that the method of inquiry adopted here does not require a comprehensive survey or cataloguing of the content and subject matter of clinical psychology. Such a task would be tremendous and perhaps impossible at the present moment because the area is so poorly organized that one would hardly know where to begin, what to include and where to end such a comprehensive survey. The present sort of inquiry seems to be a necessary preliminary undertaking before such a survey could be made.

### 3. Justification And Further Description Of The Method

From the viewpoint of the actual procedure employed in carrying out this study, it may be stated that the method involves perusal of the literature of clinical psychology and of related areas rather than some sort of experimental or empirical investigation. As this is unusual and indeed untraditional in psychology today, it perhaps requires special justification. The opinion is offered that from a pedagogical viewpoint an equal amount of value may be obtained from both types of investigation or study, and that the type employed here affords an excellent kind of preparation for professional clinical work. That is, from the standpoint of preparation for the handling of actual clinical situations, leaving aside the question of preparation for handling specific research problems, this type of study affords an opportunity for acquiring a broadened outlook and more flexible attitudes toward clinical problems. This outlook should prove invaluable in view of the controversial nature of these problems.

With respect to the more important consideration of whether this type of investigation makes a contribution to clinical psychology, the opinion is offered that the uncertain status of clinical psychology today demands the sort of study attempted here. Some of the reasons why

such a study is necessary in relation to the present status of clinical psychology have already been indicated, and many other reasons should become apparent in the course of discussion. The reason that seems relevant to mention here, however, is that even from the viewpoint of an empirical investigation the present study should prove to be a valuable contribution, for experimental or empirical studies carried out in uncharted areas are likely to prove meaningless and fruitless. A conceptual background seems necessary even to begin to define the problems which may be profitably attacked by empirical investigation, and such an orientation is unquestionably necessary for discerning the significance of the results of empirical studies.

C. R. Griffith (1), in pointing up the importance of studying the conceptual problems involved in developing a systematic general psychology, a task with which he is primarily concerned in the work cited, incidentally mentions the importance of studying the conceptual problems in the field of mental hygiene. His remark seems equally applicable to what is here regarded as clinical psychology. He writes:

All students of mental hygiene are agreed that the solution of no group of problems holds more of consequence to the welfare of society than those which will throw light upon the way in which comfort, ease, and excellence in personal and social living can be promoted; but progress

about such matters is being markedly retarded by utter confusion over concepts and methods. . . .

(1, footnote p. 20)

In the words of the recent editorial article in the first number of the JOURNAL OF CLINICAL PSYCHOLOGY, the same point is made more directly in relation to clinical psychology:

It is obvious that the entire field of clinical psychology should be surveyed and formally organized immediately. Psychologists have a professional obligation to make available their services to the general public on as large a scale as possible . . . . (2, p. 7)

The present study represents an initial step in the direction of clearing up the confusion over concepts and methods. It is a step toward formally organizing clinical psychology, but a formal organization in any strict sense is not at all attempted. It was difficult enough for Griffith, as it would be for anyone, to attempt a systematic appraisal of general psychology on a formally coordinated level, but clinical psychology does not appear at all ready for organization on a completely formal level. If Griffith, by way of illustrating the uncertain status of general psychology, and indicating the need for a systematic appraisal of general psychology could write the following, how much more dramatically the case could be stated with regard to clinical psychology! He writes:

Men say that psychology is facing in the right direction, and that it is not facing in the right direction; that its methods are adequate to its subject matter, that its methods are not adequate to its subject matter; that its subject matter should be states of consciousness, the intrinsic powers of the mind, the course and organization of mental processes, the conditions of experience, or the unique functions of an intact organism, and that its subject matter should be reflexes, responses to stimuli, reactions, behavioral acts, or dynamically organized modes of adjustment; that its procedure should be agenetic, analytical, and molecular; that its procedure should be configurational, functional, and molar; that it should be affiliated with biology or is, indeed, a branch of biological science; that it should not be affiliated with biology, because its nearest relatives are the novel, the biography, the humanities, and the normative disciplines; that it should be strictly positive, having no traffic with philosophy and eschewing all values; that its natural habitat is among the systems of moral, social, and religious philosophy; that it should treat of the composition and structure of a unique phenomenal order known as direct experience, and which is equal to the whole of reality; that it should treat of acts, powers, faculties, or functions exercised in connection either with phenomenal reality or with physical reality; that it should begin its work with abnormal types of adjustment, or with primitive drives and urges, and the lusts of small children, or with the behavior of the lower animals; that its obvious point of departure is introspective evidence furnished by the average, mature, normal adult; that, at any rate, it is a science; that at any rate it is not a science; and that, furthermore, it never can and never should attempt to become a science. (1, p. vii)

The problems with which Griffith is confronted in formulating the principles of a systematic general

psychology are highly relevant and similar to those which confront the present writer, for clinical psychology is derived from general psychology to a great extent so that its problems are related though not identical. Nevertheless, the present study operates on a less formal level than that upon which Griffith's work proceeds. In another sense, it is more general than that of Griffith's study; it attempts to determine the bearings of clinical psychology and to gain a perspective and an enlightened outlook as to the direction of its course.

Justification of the present type of study may be furthered in terms of a comparison with philosophy. The method of inquiry is similar to what might broadly be termed the philosophical method. The subject matter does not, of course, belong to philosophy in any technical sense, though some aspects of clinical psychology, particularly those concerned with ethics, are derived directly from philosophy. A category that may be called "the philosophy of clinical psychology" might better convey the meaning and purpose of this study and describe well its predominating spirit.

This study may be classified as an effort to develop a philosophy of clinical psychology in that it also attempts to develop what might be called a meta-clinical psychology. The present study endeavors to point the way toward the development of a generally acceptable,



intelligible language for talking about clinical psychology which might lead to its recognition as a generic discipline. At the present time there is no such language in terms of which the various seemingly contradictory aspects and opposing ideas may be readily understood and discussed. The present situation is a Tower of Babel wherein a particular aspect, theory, or method tends to be interpreted only within its own narrow set of terms without reference to a more general framework. The result is that impartial critical evaluation and judgment are extremely difficult to achieve with respect to a specific aspect, theory or method.

It will readily be admitted that such a situation is unsatisfactory and should be remedied as soon as possible. However, it must be emphasized that the present effort is not expected to yield any clear-cut remedy, or any formally well organized system of clinical psychology. It is intended to pave the way toward the possibility of formulating such a system insofar as it successfully grapples with the controversial problems and issues which now block the road. Clear-cut formulations of the problems and issues themselves may not always be possible, much less a formal systematization of the whole area, for the problems and issues present themselves at various levels of meaning and significance, for example, the philosophical, the logical, methodological, ethical, practical, and



technological. Their content, moreover, may be psychological, psychiatric, or sociological.

Sometime after the idea of the present study was conceived and the work begun, the writer came across the published doctorate study by Virginia P. Robinson in which she pursues a task with respect to the social case work field similar to what is attempted here in respect to clinical psychology. The final paragraph of the introduction to her work seems strikingly pertinent in that it expresses the spirit and intentions of the present effort in an admirable way. She writes:

This formulation will have served its purpose if it suggests problems rather than solves them, and if it stimulates others to the formulation of differing points of view. I am convinced that case work theory must progress as other scientific theory has progressed, by the frank expression of difference, by discussion, argument, controversy. Another ten years and the process will have moved forward, the problems will have shifted to another focus, new values will have emerged out of the relationships which case workers are creating, and the movement will demand a new and different formulation. The formulation I have attempted in the following pages has no value beyond the temporary one of serving as a step in this process, on the basis of which new and more nearly adequate formulations may be made in succeeding phases of the movement. (3, p. XV)

The present study, then, presents arguments and controversies; its spirit is exploratory, reflective and critical; its answers are temporary, incomplete, and suggestive.

## Chapter I

### GENERAL STATUS OF CLINICAL PSYCHOLOGY (1947)

Clinical psychology as a science and profession has a singularly enigmatic status from several points of view. As a profession, it has mushroomed in recent years in extensive ways and in diverse places under various situations and circumstances. Yet this rapid growth has been marred by several blemishes and has given rise to many sorts of problems. The purpose of this chapter is (1) to present evidence of the rapid growth, (2) to indicate the nature of some of the blemishes on that growth, and (3) to indicate the major areas of growth. A background and a point of reference will be provided for the later discussions of the problems and issues that beset clinical psychology. Emphasis will be on its general status with some more or less specific reference to its status as a science and profession. It is obvious that status as a science is intimately related to status as a profession, so that separate discussion is bound to be somewhat artificial, on the one hand, while on the other hand, some mixture of questions involved is to be expected. Whatever confusions may arise, will be erased, it is hoped, by the later more specific and detailed discussions. The present chapter, then, is a preliminary survey of the general status of clinical psychology.

## Part I

### 1. Signs of Growth

There are many clear signs of continued growth in response to the strongly voiced demands for the services offered by clinical psychology. The founding and publication of a new journal, THE JOURNAL OF CLINICAL PSYCHOLOGY, in January, 1945, may be taken as one important sign of its recent growth. It is of interest to quote from the opening article by the editors of that journal, an article intended as a brief survey of the field and status of clinical psychology:

All signs indicate that clinical psychology is on the threshold of an unprecedented expansion and consequently there is need for a scientifically oriented professional journal dedicated to the advancement of the clinical method in psychology.

(2, p. 19)

Also to be noted is the fact that the JOURNAL OF CONSULTING PSYCHOLOGY was founded as recently as February, 1937. The editorial policy of that journal is stated on the cover as being designed to publish:

results of research having a bearing on the applications of psychology, short articles and communications relating to professional psychological service, reports of activities of the Association of Consulting Psychologists and other organized groups of professional psychologists, information relating to resources available to members of the profession and critical reviews of recent literature.... (4)

There are, of course, many other journals and scientific periodicals which carry reports of research and other materials relevant to clinical psychology. A number of these journals will be mentioned in the course of this study. The present purpose is merely to point to recent evidence of the growth of clinical psychology as an entity.

The extensiveness of the demand for the services offered by clinical psychology becomes partly apparent in connection with the efforts to pass a National Neuropsychiatric Institute Act. This proposed legislation is intended "to provide for, foster, and aid in coordinating research relating to neuropsychiatric disorders; to provide for more effective methods of prevention, diagnosis, and treatment of such disorders; to establish the National Neuropsychiatric Institute; and for other purposes." (5, p. 1) The legislation points to the demand for the services of clinical psychology as well as for the services of other disciplines including psychiatry. In this connection, Surgeon General Parran, U. S. Public Health Service, states, in the Hearings on the above Bill:

"The need for many more psychiatrists in all fields of practice is basic. At present there is a deficit of from 3,500 to 4,000 psychiatrists in publicly supported institutions alone." He further adds that "to conduct an adequate public mental health program will require an additional 1,800 psychologists, 14,000 psychiatric nurses, 6,000 psychiatric

social workers, 1,400 occupational therapists, 15,500 attendants, and some 3,400 other technical personnel."  
(5, p. 18)

This fact along with some other relevant facts are mentioned in a recent editorial which appeared in the JOURNAL OF CLINICAL PSYCHOLOGY;

These are boom days for psychologists, especially for those with training in the clinical and counseling areas. The Veterans Administration hopes to employ some 4700 clinical and counseling psychologists as soon as they are available. The Federal Security Agency wants 2100. The Re-employment Administration can use upwards of 2000 more and the U.S. Public Health Service may ultimately be expected to put in its bid for 1500 clinical psychologists with the Ph.D. degree. The plans for the employment of clinical and personnel psychologists in the Armed Services have not yet been announced. . . . (6, p. 396)

An initial impression of the rapidly and vigorously expanding science and profession of clinical psychology has been given. Now, the growth will be viewed from another angle, that is, from within the profession itself. John G. Darley and Ralph Berdie (7) published a report in 1940, of a survey of the field of applied psychology with respect to the duties of applied psychologists as reported by them in response to a questionnaire. It is interesting to note that of the 1124 applied psychologists replying to the questionnaire, 300 classified themselves as clinical psychologists, 81 as psychometricians, 74 as consulting psychologists, and

345 as educational psychologists. It is significant to interpret these figures in the light of the data that show a tremendous overlapping of the duties reported by these psychologists. There was a .75 correlation between the duties reported by those classifying themselves as clinical psychologists and those classifying themselves as educational psychologists; a .71 correlation between the duties of the clinical psychologists and those who call themselves psychometricians; and a .65 correlation between the duties of the clinical psychologists and those who call themselves consulting psychologists.

Clearly, clinical psychology in some of its aspects and techniques seems to pervade a large area of applied psychology. Eight hundred or 71% of the 1124 applied psychologists participating in the survey appear to use clinical psychology in some respect in their professional work. This seems to point to the existence of a generic clinical psychology the nature of which has never been made explicit enough to be recognized.

It seems pertinent to the picture of the rise of clinical psychology from the viewpoint of the profession itself, to cite the findings of G. W. Allport. (8) In examining periodical literature in significant psychological journals from approximately 1888 to 1938, he discovered that there was a lessened interest in applied psychology and in clinical psychology in recent years.



Though clinical psychology is not mentioned as such, what Allport speaks of as an interest in the single case is taken here to be more or less identical with an interest in clinical psychology. Allport defines an interest in the single case as being represented in journal articles which are "directed toward the understanding of the individual event, based upon intensive studies of clinical cases, individual persons, or single historical events, stressing the setting of the case in its life-environment." (8, p. 6)

Allport interprets the finding with regard to the lessened interest in applied psychology in terms of a cleavage that seems to have developed within the profession of psychology as a whole, a cleavage based on the difference between "pure" and applied psychology. He writes:

The conclusion to be drawn, I think, is not that our membership as a whole is less interested in the usefulness of psychology, but that a certain professional cleavage is developing. Psychologists using the fourteen journals studied are, in their writings, becoming more and more remote from living issues and more abstract in the presentation of their subject matter. The consulting, applied, and socially-minded psychologists are turning to other, more specialized, journals not included within our survey. Thus, the indication is that "pure" and "applied" psychology are parting ways to some extent--an event which some will deplore and others welcome. (8, p. 7)

It appears then, that clinical psychology and applied psychology is growing from the standpoint of the number of articles devoted to its subject matter even though an opposite impression might be gained from an examination of the "pure" psychological literature in the more standard or academic psychological journals. It should be noted that Allport's study does not go beyond 1938, and the present situation might well be different as a result of the war. However, whether the growth of clinical and applied psychology is expressed in articles appearing in the purely academic journals or not, the fact remains that it is being expressed.

Another, more recent confirmation of the growing interest in applied fields of psychology, may be seen from a report by E. R. Hilgard (9). In presenting a summary of divisional preferences (relative to the revision of the organization of the American Psychological Association) of 3,680 respondent psychologists, Hilgard notes:

that the center of gravity of interest of psychologists has shifted toward applied fields is evident in the three choices which lead, both in the expressed primary preferences and in the secondary preferences: clinical (53% of total\*), personnel (47% of total), and child (44% of total). (9, p. 22)

Educational, consulting, and industrial psychology are next in order of preference.

---

\* Percentages taken from Table II in the article cited.



An interesting corroboration of the findings noted earlier in the Darley and Berdie report relative to the overlapping of psychologist's duties in formally and conventionally separate areas, is the finding noted by Hilgard (9) that preferences for abnormal, clinical, and consulting tend to form a cluster. This appears to indicate that psychologists interested in any one of these areas tend to be interested in all three areas simultaneously. There seems to be a strong functional inter-relationship among the areas which again seems to point toward a generic discipline.

The data referred to in the reports of Darley and Berdie, as well as those from Allport and Hilgard, give rise to many problems and issues concerning the definition of clinical psychology and other areas within applied psychology which will be dealt with in later discussions. Here, the attempt has been simply to give some indication of the scope of clinical psychology.

## 2. The Issue Of Charlatanism

While the growth of clinical psychology has been vigorous, it has not occurred without blemish. Charlatanism constitutes a grave disturbance to the growth and status of clinical psychology. Psychology, and especially clinical psychology lend themselves all too readily to facile theorizing and harmful practices based upon ill-considered

ideas. R. A. Brotemarkle (10) points out that the very nature of psychology encourages quackery because of the ideational, intangible, illusory content. He indicates the extensiveness of the problem of quackery in the following statement:

The specific challenge of quackery to Consulting Psychological service is probably greater than to any specific service to-day save the diversified field of religious cult practice in which may be found the origins of the quack and to which he even now seems prepared to take final flight.

(10, p. 12)

The attention of the editors of the JOURNAL OF CLINICAL PSYCHOLOGY also is given to the problem of quackery as evidenced by the following editorial comment:

Large display advertisements have recently appeared in several metropolitan daily newspapers advertising the services of "personality advisors" and "counselors in human relations" who propose to analyse the self-advancement assets and liabilities of anyone who will mail in one dollar. . . . It is inevitable that the current demand for professional psychological services would result in the sudden appearance of a large number of untrained and unethical quacks attempting to capitalize on the public's awakened interests in psychological matters. The activities of such self-appointed psychologists and charlatans can only operate to discredit professional psychology and be harmful to persons genuinely in need of competent counseling. One of the responsibilities of professional psychology is to unceasingly combat the activities of all charlatans who aspire to professional ranking without adequate training. . . . (6, p. 398)

One needs only to turn to a recent book by Lee Steiner (11) to find many detailed and documented accounts of the practices of pseudo-clinical psychologists and self-styled counselors. But granting the magnitude of the problem of quackery, the question becomes, at least on a theoretical or reflective level; What are the major objections to quackery?

At first, the answer to this question seems ridiculously obvious. Quackery is simply unscientific and unethical, and, in general the enlightened have little trouble in distinguishing the quack from the genuine. On second thought, however, it becomes almost equally clear that a more thoroughgoing, and more satisfactory answer involves many considerations which in turn involve many of the problems and issues that are being studied in this entire inquiry. It should also be noted that within the professional circle itself, it is often extremely difficult to distinguish between and obtain agreement upon what constitutes some forms of quackery. What is considered sound procedure by some, may be considered by others to be based on false assumptions or theories that produce harmful results in clinical practice. This may amount to quackery even though there may not be wilful intention present.

This whole study may, in a general sense, be considered an answer to the problem of quackery. The

chapter on the ethics of clinical psychology is aimed at providing a more direct answer. For the moment, it is sufficient to indicate that part of the answer to the question posed above relative to the theoretical objections to quackery centers around the fact that quackery always proceeds on a monosymptomatic as distinct from a polyosymptomatic basis. This fact is pointed out by W. Stern (12) who further indicates that the monosymptomatic method always leads to narrowness and inexactitude. It is a method, as the term implies, which seeks to explain the complexities of human behavior and conduct on the basis of one or a few assumptions or theories regarding only one aspect of human behavior. Often these assumptions are false in themselves though they may be well founded in the sense that they are based upon astute but incomplete observations. It is for this reason that Stern warns that a specific form of quackery should not be summarily discredited. The findings and observations of quackery may and often do furnish valuable leads and insights which can be developed on a scientific basis. Stern cites the field of graphology as an example of one which has been developed from leads adopted from quackery where it originated. The field of hypnosis may also come to mind in this connection as an example of a topic which formerly was part of quackery and now has a demonstrated scientific standing.

### 3. Relationships to Allied Professions-- especially Psychiatry.

The status of clinical psychology as a profession is also marred by the fact of its uncertain and equivocal relationships to allied areas of professional practice. Evidences of this state of affairs especially in relation to psychiatry and to some extent social case work are all too abundant. Most clinicians can offer testimony from their sometimes painful experiences in this regard. With respect to psychiatry the situation developed concurrently with the beginning of the rapid growth of clinical psychology. This may be seen from Carl E. Seashore's account of a conference on April 30, 1920, on the relations between psychiatry and psychology. Writing in 1940, Seashore states:

Twenty years ago organized psychology and psychiatry were at swords' points, and the time had come for a truce in this warfare. At the time both professions had discovered a new territory and found themselves upon an exciting frontier; both had rushed in to secure squatter claims and were in no mood for friendly relations. In this territory loomed the problems of dealing with all types of mental disorders in their inceptive stages in very large numbers in education and society; but neither psychologists nor psychiatrists had penetrated the region enough to realize the full nature and magnitude of the discovery.  
(13, p. 126)

Concerning the issues covered at this 1920 conference, Seashore further states:

There was in the situation every element of intensive war. Both sides were contesting for "living space." Each considered the other an intruder. Neither had developed an adequate administrative conception of the situation. Each was inadequately staffed for dealing with the situation. Very few, if any, had any real conception of the magnitude and the nature of the responsibilities involved. Both factions were more or less frustrated, not only with the opposing faction but with their own groups. Look at psychology. The war had put all but a handful of the leading psychological laboratories out of commission temporarily; and as a result of the success of the army tests, there was a grand rush into the field of paper and pencil testing as a substitute for laboratory and clinical research. New schools of psychology were becoming sufficiently conspicuous to cause unrest and distrust. The public was imposed upon by charlatans who posed under the name of psychology in their frauds of diagnosis, guidance and treatment. The clinical section of the American Psychological Association had just been formed and was beginning to analyze the situation. In this group there were some very able psychologists but very few technically trained clinicians. Efforts were being made to define clinical psychology and to secure legislation to protect that profession. A very delicate issue was the question of the right to charge fees for practice and that fell back on the issue of medical certification. Presidents and heads of departments of psychology in leading universities were not aware of the situation in any effective way. But psychologists from all sources were confronted with cases in large numbers and endless variety, clamoring for help. And what should they do? The leaders admitted their inadequate training, their absence of adequate certification, and the strong opposition from the medical profession. In short, it now seems strange that psychology as a science got through that period without losing all standing among the older sciences.



The ramifications of the situation pointed out by Seashore are almost as wide as these of the present study, and some aspects of it have already been touched upon. Unfortunately, the difficulties in the situation have not yet all been resolved. But, the historical picture may be rounded out a bit further by noting with Seashore that the status of psychiatry in 1920 was almost as uncertain as that of clinical psychology. Psychiatry was not generally recognized as being respectable, and the medical profession as a whole had no real awareness of the extent and significance of mental illness. There was, Seashore points out, little agreement within psychiatry as to theory or as to practice. Medical schools did not furnish any training in psychiatry, Psychiatrists obtained their training in a haphazard fashion, in most cases simply through an internship at a state institution. They learned only by hard experience gained without benefit of organized supervision.

The friction that existed at an early date between clinical psychology and psychiatry can be sensed from the language of a report and recommendations adopted by the New York Psychiatric Society and published in 1917 (14). The report was based upon an inquiry into the activities of psychologists carried out by a committee appointed by the Society. The report states it was particularly concerned with those psychologists who "termed themselves

'clinical psychologists' in relation to the diagnosis and treatment of abnormal conditions." (14, p. 224) The society made the following recommendations:

1. We recommend that the New York Psychiatric Society affirm the general principle that the sick, whether in mind or body, should be cared for only by those with medical training who are authorized by the state to assume the responsibility of diagnosis and treatment.
2. We recommend that the society express its disapproval and urge upon the thoughtful psychologists and the medical profession in general an expression of disapproval of the application of psychology to responsible clinical work except when made by or under the direct supervision of physicians qualified to deal with abnormal mental conditions.
3. We recommend that the Society disapprove of psychologists (or of those who claim to be psychologists as a result of their ability to apply any set of psychological tests) undertaking to pass judgment upon the mental condition of sick, defective or otherwise abnormal persons when such findings involve questions of diagnosis, or affect the future care and career of such persons. (14, p. 225)

It is interesting to note that S. I. Franz (15) discussed the above recommendations at the time of their publication, in a highly critical manner. Franz pointed out the implication of mutual distrust between the two professions and the need for getting at the basis of the distrust as well as the need for establishing a cooperative working relation-



ship between the two professions. Franz maintained that the realm of abnormal phenomena should not be the exclusive concern of either psychiatry or psychology. To maintain otherwise, he believed, could only be done on the basis of prejudice or poor logic.

#### 4. Some Aspects Of The Present Problem Of Professional Relationships to Psychiatry.

That the problem of the relationship between clinical psychology and psychiatry is not merely of historical interest, but on the contrary is of major concern today, may be illustrated by the number of articles treating this topic. To be noted among these, is the opening editorial article in the JOURNAL OF CLINICAL PSYCHOLOGY, January, 1945, which seems worth quoting in detail because it summarizes important aspects of the problem and mentions the signs of progress toward its solution.;

One of the most perplexing problems in the development of clinical psychology has been the matter of interprofessional relationships with other psychological sciences. Not only has there been some suspicion and lack of cooperation between academic and clinical psychologists but the gap has been much wider between psychology and psychiatry. It is indeed paradoxical that such a wall of negative emotions and intellectual disrespect should have been allowed to develop between two psychological sciences which have even stooped so low at times as to harbor paranoid ideas concerning each other. Psychologists have frequently

been most unscientifically resentful and jealous of the professional successes of psychiatry, while psychiatrists have sometimes assumed a patronizing attitude toward their psychological colleagues because of their lack of a medical background. At various times since World War I abortive attempts have been made to bring together psychology and psychiatry for the purpose of delineating their respective fields of operation and establishing more cooperative professional relations. Unfortunately no genuine rapprochement has yet occurred, although in isolated places individual psychiatrists and psychologists have learned to work together and in so doing gained mutual understanding and respect.

It is reassuring to note many evidences of increased cooperation and respect among all the psychological sciences. World War II has abruptly created a new and unprecedented demand for all types of psychological service which can only be met by harmonious unified action on the part of all those concerned. . .

In his critique of American psychiatry presented at the 1944 centennial meeting of the American Psychiatric Association, Gregg\* emphasized the urgent need of bringing together the psychological sciences in closer cooperation and suggested that psychiatry should welcome psychologically trained personnel into its ranks. Menninger\*\*, speaking from his experiences as director of neuropsychiatry in the U.S. Army, stresses the value of closer professional relations between psychology and psychiatry and expresses the hope that "sometime our medical schools can become sufficiently universities to include in their training these intimate associates." Professional psychology has a valuable contri-

---

\* Gregg, A. Critique of American Psychiatry. Paper read at Centennial Meeting, American Psychiatric Association, Philadelphia, May, 1944.

\*\* Menninger, Col. W. C., M.C., AUS "Expanding Fields In Medicine and Medical Education: Neuropsychiatry." J. AMER. MED. ASSOC., 1944, 125, 1103-1105.

bution to make through its long development of experimental methods and training in objective thinking, while psychiatry can reciprocate by making available clinical materials and training resources without which clinical psychology will be seriously handicapped. Perhaps the most hopeful omen in the direction of improved interprofessional relations is the recent appointment of cooperating committees representing the American Psychiatric Association, the American Psychological Association and the American Association for Applied Psychology to consider the problems relating to common interests. Much of the suspicion and prejudice of the past has been the result of misunderstanding and lack of cooperation. . . . (2, p. 13)

Other articles which may be cited by way of illustrating the present concern with the problem are those by H. Babcock (16), M. A. Seidenfeld (17), and M. Ives (18). Babcock is rather extreme in her views about the role of psychiatry as related to clinical psychology and Seidenfeld's article appears as a needed critical reply to Babcock. Babcock would separate and delimit the functions of psychiatry and psychology in an extremely sharp way by maintaining that psychology is exclusively concerned with the mind and mental functioning while psychiatry as a branch of medicine is exclusively concerned with bodily and physiological functions. The extremity of Babcock's position may be seen from the following:

A physician is a person fitted by his knowledge of the physically sick and well to treat the physically sick. A psychologist is a person who by study of

an experience with normal and abnormal behavior under conditions of scientific control is able to help in problems of personal adjustment. A psychiatrist is a person educated in physiology and medicine who tries to help in problems of personal adjustment where his training in medicine is of little use and his training in psychiatry is apt to be misleading. (16, p. 254)

Seidenfeld appears to have a much more open and broadminded attitude in that while he is able to agree with Babcock that psychology has something special to offer in the realm of mental functioning and efficiency, he is not willing to exclude psychiatry from contributing to this realm. Seidenfeld's attitude is to encourage harmonious cooperation between the two professions, each recognizing the contributions of the other.

The attitude of Ives is quite similar to that of Seidenfeld in that the stress is placed on the need and value of cooperation between the two fields. Ives points out that psychology began with an interest in the normal but has of necessity become concerned with the abnormal, and with the deviate. Psychiatry, on the other hand, began with an interest in the abnormal but has recently become concerned with the normal or near normal. Both are now concerned with the same groups of individuals. Ives believes, however, that each profession approaches the individual differently by virtue of differences in preparation and outlook. Ives concludes from this that;

they (the two professions) should be mutually helpful in arriving by various means at a better understanding of the individuals concerned. (18, p. 146)

Another extreme view, though unfortunately in all probability a current one among many psychiatrists, is that expressed by G. Zilboorg (19) in a recent book. Zilboorg, a prominent psychoanalytic psychiatrist, forms his opinion on the basis of a definition of psychology in academic terms, as being almost exclusively concerned with the general laws of human behavior. He is willing to admit that psychology has nevertheless made some contributions in applied fields, and that it is sometimes concerned with the individual. This occurs rarely, however, and in respect to very limited vocational and educational problems. Zilboorg writes:

Psychology has become of recent years an interesting and useful discipline in the field of sociological and philosophical endeavors. It deals with people in general, mind in general, emotions in general. If it does individualize its studies at all, it does so for some specific sociological purpose, such as vocational training, or employment service, or classification of aptitudes for schoolwork; but as a rule it seeks a formula for the average man. It knows nothing of disease at first hand, for psychology is not accurate science or art. It cannot be, for the psychologist is not a physician. (19, p. 19)

In following Zilboorg's argument, it soon becomes apparent that the main ground of contention for him is not the issue of whether psychology deals with the general or

the individual, but, rather, the issue of whether anyone but a physician can possibly be justly concerned with therapy. He pursues this point in his next sentence:

Is it necessary to be a physician, if you know well how the human mind works? It is more than necessary; it is imperative. Any attempt on the part of a psychologist to treat and to cure any sick person is charlatanism, no matter what cloak of respectability he may wear. One of those cloaks is frequently called "re-education," as if a neurotic or a psychotic . . . is neurotic or psychotic by virtue of improper education. And even if improper education were actually the cause of mental illness, it does not mean that the individual thus afflicted can be taken in hand like a clock, turned back, and reset by some sort of re-education. Whatever the cause, the treatment of the consequences is a highly specialized and frequently a grim business. The psychologist can never make a differential diagnosis between a purely physical and a psychological affliction, because he is not trained in medicine or psychiatry, no matter how long he may have been in the neighborhood of and in loose contact with mental hospitals and patients. Mere intelligence and a good knowledge of academic psychology do not provide him with true knowledge of the sick human being. (19, p. 19)

It may be noted that while Zilboorg is mainly concerned with proving the incompetence of psychology in therapy, the extremeness of his view forces him to exclude psychology from the field of diagnosis as well. Insofar as this is logically necessitated by his position, the position tends to be reduced to an absurdity, for to exclude the contributions of psychology from diagnosis as well as therapy is to relegate the whole field of clinical psychology to the limbo of quackery.



But to return to the question of therapy which remains Zilboorg's main concern, the basis for his belief that only a physician can possibly treat or cure is his concept of "therapeutic intent." Therapeutic intent is acquired by a physician during the course of his medical training and can only be acquired by a physician. It can only be acquired by a physician by virtue of the fact that only he has long years of contact with illness and thus learns to know illness deeply and to feel deeply responsible for treatment. In further describing the concept, Zilboorg states:

This therapeutic intent is not merely an intellectual perception of a wish to cure; it is a need to cure. It becomes an integral part of the medical man's psychology. . . . The therapeutic intent is not a form of sentimentality or formal professional piety. It is a psychological function, developed only in hospitals and clinics where discernment and detachment, serenity and concern, are singularly combined. . . . (19, p. 21)

Zilboorg admits the theoretical possibility that medical training does not inevitably produce the therapeutic intent in a particular case, but he firmly holds that therapeutic intent can never be acquired in any way except through medical training. He writes in this connection;

But it is a matter of cold practical fact that he who has never gone through all the steps of medical training will never develop any true therapeutic intent, nor will he acquire the psychological balance with regard to illness. Therefore he cannot and may not treat sick people. The psychologist

who treats or re-educates sick people is equipped to do neither but claims to do both. (19, p. 22)

Zilboorg states that many people are beginning to realize the truth of his position and that the psychologist seems destined to limit himself within his proper sphere which Zilboorg somewhat condescendingly refers to as a "valuable speciality." He notes, however, that there are certain psychologists who refuse to be limited in that manner, and who call themselves clinical psychologists. Of these, Zilboorg writes:

The refractory ones have developed the appellation of "clinical psychologist," a term which would imply that it is possible to be a layman, a psychologist, and a clinician--that is, a psychiatrist--combined.\* This term is obviously a misnomer. Terms and words do not change the substance of the problem, but we do frequently conceal the substance behind terms and words.  
(19, p. 23)

The problems and issues involved in Zilboorg's argument will be discussed in greater detail at several other places in the present thesis, but here it should be noted that it is possible to agree with Zilboorg's notion of the necessity for therapeutic intent in any form of treatment and yet to disagree with his notion that therapeutic intent can only be acquired through medical training in a medical school. The relevant aspects of

---

\* Zilboorg also speaks of "consulting psychologists" in the same disparaging tone. (19, p. 12)



medical training that have to do with mental illness and acquiring therapeutic intent relative to mental illness may conceivably be acquired during the course of a curriculum set up specifically for the training of clinical psychologists as well be discussed later.

## Part II

### The Areas In Which Clinical Psychology Functions

A large part of the difficulty in ascertaining the status of clinical psychology appears to lie in the fact that clinical psychology may be found to operate in a great variety of areas. This fact was alluded to earlier in the discussion but here it seems necessary to mention specifically the most important of the areas within which clinical psychology is operative. No attempt will be made to cover any of the areas exhaustively. The aim, rather, is to provide illustrations of the varied functioning of clinical psychology, and to enlarge the basis for ascertaining and evaluating the status of clinical psychology. The areas which will be described represent the media, so to speak, in which clinical psychology has taken root, and in which it seems destined to grow. The term "media," however, is not wholly adequate here unless it be understood to connote that the growth takes place in response to needs and demands for the services of clinical psychology. An

attempt will be made, then, to bear in mind the intimate relationship between areas, needs, and demands.

### 1. The Armed Services: World War I

In the First World War, Robert M. Yerkes was chairman of "The Psychology Committee Of The National Research Council" which was organized to initiate and formulate psychological work in the Services. Yerkes (20) published a report of the work of this committee in which he reviews the accomplishments and achievements of psychology as related to the war effort. Yerkes (21) also edited a voluminous, detailed report of the methods and results of psychological examining during World War I.

In summarizing the World War I background of experience in personnel and psychological services, Yerkes (22) in a recent article, mentions two main phases of work, namely classification of personnel and psychological examining. Concerning the former, Yerkes quotes General McCain\* as follows:

The importance of personnel work was early recognized and the development of an adequate personnel system for the United States Army entrusted to a group of specialists who were called by the Secretary of War . . . . The system worked

---

\* Foreword by H. P. McCain, Major General, U.S.A., Formerly the Adjutant General, Volume I, HISTORY OF THE PERSONNEL SYSTEM, The Personnel System of the United States Army. 1919, Washington.

out by this group is probably the most effective now in existence. Its purpose is (1) to secure a contented and efficient army by placing each enlisted man where he has the opportunity to make the most of his talent and skill; (2) to commission, assign and promote officers on merit and (3) to simplify the procedure of discovering talent and assigning it where most needed. . . . (22, p. 207).

Concerning psychological examining, Yerkes writes, in part:

Methods were especially prepared to meet military requirements, and nearly two million recruits were examined, classified and reported on to commanding officers and to the headquarters in the Office Of The Surgeon General.

Psychological examining constituted a novel, pioneer military service, the results of which the Army was not then well prepared to use advantageously. Nevertheless, practical values were widely recognized by experienced officers, and in many commands highly appreciated . . . . (22, p. 208)

From the standpoint of the problem of the status and of the definition of clinical psychology, it is interesting to note Yerkes's recent thinking in terms of "human engineering" and his comments, in this connection, about the relationship between personnel work and psychological examining. Yerkes writes:

These two developments, classifiable as human engineering, that of trade testing and personnel classification in the Adjutant General's Office and that of psychological examining and classification in the Surgeon General's Office, undoubtedly should have constituted one service under a single appropriate military organization . . . . (22, p. 208)

In addition to the administrative implications, Yerkes's concept of human engineering seems to have implications concerning the nature of clinical psychology or, rather the value of the clinical approach insofar as it implies a concern for the whole individual as a human being. In actuality, however, psychological work in World War I was, on the whole, not conceived as clinical psychology in the sense of a primary concern with the individual. This is clear from a review of the literature on the classification of military personnel by T. W. Harrell and R. D. Churchill (23). The emphasis was on the development of large scale techniques for the measurement and evaluation of intelligence, aptitudes, skills and abilities of large masses of men from the point of view of the efficiency of the Army as a whole. The individual was neglected from the point of view of his own personality needs except insofar as those needs happened to coincide with those of the Army.

## 2. The Armed Services: World War II

The emphasis on the efficiency of the group as a whole rather than on the individual noted during the first World War was continued during the early years of World War II, as pointed out by the Staff Of The Personnel Research Section, Adjutant General's Office:

The Army classification system has developed in the swift current of events; techniques and procedures have been evolved

to meet the most urgent needs of the moment. Consequently, it has been concerned primarily with the problems of mass evaluation and classification and has focused attention on the measurement of skills and capacities. With the goal of expansion already attained, the Army can afford to turn more attention to the problems of its efficient operation. And this implies attention to the individual soldier. . . . (24, p. 105)

The Staff goes on to note that a concern for the individual came relatively late in the War and they review the developments in this area:

The application of psychological techniques to the problems of individual adjustment constitutes a relatively recent trend in Army personnel work in this war (W. War II). Classification and Assignment Officers, Personnel Consultants, and others have made beginnings in this work in Consultation Services (a), Mental-Hygiene Units (b), Developmental Training Units (c), Rehabilitation Centers (d), and Separation Centers (e). More recently,

- 
- (a) McQuitty, L.L. "A Program for the Classification and Training of Retarded Soldiers," PSYCH. BULL., 1943, 40, 770-779.
  - (b) Deutscher, Max. "The Clinical Psychologist in an AAF Mental Hygiene Unit," PSYCH. BULL., 1943, 41, 543-547.
  - (b) Freedman, H.L. "The Unique Structure and Function of the Mental Hygiene Unit in the Army," MENTAL HYGIENE, 1943, 27, 608-653.
  - (c) Staff, Classification Section, Classification Branch, AGO. "An Army Experiment in Retraining Psychoneurotic Casualties," PSYCH. BULL., 1944, 41, 519-523.
  - (d) Lipkin, Stanley. "The Personnel Consultant in an Army Rehabilitation Center," PSYCH. BULL., 1944, 41, 524-531.
  - (e) Evans, Colonel George R. "The Army Separation Classification and Vocational Counseling Program," OCCUPATIONS, 1944, 23, 69-74.

clinical psychological services in Army hospitals have been substantially expanded as indicated by the inauguration of the office of the Chief Clinical Psychologist in the Classification and Placement Branch of the Adjutant General's Office (f). (24, p. 105)

M. A. Seidenfeld (25), Chief Clinical Psychologist in the Office of the Adjutant General, makes the same point regarding the relatively late development of clinical psychology in the strict sense of implying a primary concern for the individual. Seidenfeld also stresses the distinguishing characteristics of clinical psychology in terms of the use of qualitative data and interpretive skills involved in making clinical judgments of the mental functioning or behavior of the individual.

In addition to developing late in the War, clinical psychology arose in a rather haphazard and unorganized fashion. As late as 1944, R. R. Sears was able to write in the following vein by way of introducing a symposium on Clinical Psychology in the military services:

The work of clinical psychologists has not been organized under any single administrative division in the military services. Problems requiring such specialized skills have arisen in many places, and individual clinicians have been assigned where they were needed. As a result, members of the profession are scattered throughout the services, and few of them, to say

---

(f) Seidenfeld, M. A. "Clinical Psychology in Army Hospitals," PSYCH. BULL., 1944, 41, 510-514.



nothing of their civilian colleagues, have had very adequate conception of the role that clinical psychological work has played in the military organization so far.

(26, p. 502)

That the lack of organization was not only administrative but also reflected a lack of clarity as to the whole nature of clinical psychology may be well illustrated by the following statement made by Sears:

One difficulty encountered in this survey (of clinical psychology in the military services) has been that of deciding just what is clinical psychology. For example, the work of classification and personnel specialists has varied from creating group tests to the interpretation of test scores through detailed interviews with the men who take them. Clinical psychology is commonly understood to be a specialty in which individual persons are examined for diagnostic or therapeutic purposes, and in which the primary aim is to be of assistance to the patient or client himself. Logically, perhaps, some classification procedures could be brought under these criteria, but actually this work is organized in immediate connection with the larger program of occupational placement and it is questionable whether the purposes of the procedures could be related as much to the welfare of the individual as to the efficiency of the military services. A similar exception could be made with the diagnostic work in Naval Training Stations, but in such instances the actual procedures are so similar to clinical diagnostic work in civil life, and the skills required are so definitely those of the trained clinical psychologist, that it would be false to ignore them as part of the total picture. There is no solution to this difficulty--in military life any more than in civil life--and no hard and fast criteria have been used in the selection of the jobs to be described. In general, these papers



cover job descriptions, research programs and technical problems that relate to diagnosis of disturbed or maladjusted persons, reclassification of men for whom the standardized group techniques have been insufficient, and reeducative or therapeutic procedures. (26, p. 503)

It should be remarked in passing that Sears probably does not mean literally the statement that "there is no solution to this difficulty," for, in that case, his entire effort represented by the symposium (27) to which reference is being made loses its significance. The entire effort represented by the present thesis would also be without significance. It is one thing to state that criteria for establishing the nature of clinical psychology should not be "hard and fast," but a different matter to state that there should be no criteria at all or that such criteria can never be found.

An additional point about psychological service in the Armed Forces should be made, namely, that even within the framework of an interest and concern for the individual--cited as the general mark of distinction of clinical psychology from psychological examining or personnel psychology--clinical psychology in the Armed Services is likely to differ from practice in civil life. This results essentially from a difference in aim or purpose. As Sears puts it:

In the services, the main task is one of making the group operate effectively as

quickly as possible and with the largest number of people. The individual's civilian aims and motives give way to his efficient performance of military duties as the principal frame of reference within which his welfare is sought, and the disposition of the cases is planned on a different basis from that used in civilian life. (26, p. 504)

There is then a finer distinction that needs to be drawn with respect to concern for the individual as a criterion of clinical psychology. On the one hand, it seems possible to have an interest in the individual and to employ individualistic techniques in studying him and yet to consider him mainly from the point of view of the group; while, on the other hand, the interest in the individual may not only express itself in the use of individualized techniques of studying him, but in a primary concern for his welfare. Clinical psychology in World War II differs from practice in the first war insofar as it employed individualized techniques of study, but it must be distinguished from clinical psychology in its more complete sense of representing a concern for the welfare of the individual. This distinction is manifested in the stress that is placed on diagnosis and classification in the Services rather than on therapy.

M. Krugman (28), in a review of recent developments in clinical psychology related to the Services, makes definite note of the almost exclusive emphasis on diagnosis

at the expense of therapy. The result has been, as is clear from Krugman's review, that most of the accomplishments in clinical psychology in the military took the form of the development and perfection of testing, of diagnostic techniques and of screening devices. This is clear also from two recent articles on military clinical psychology by W. A. Hunt and I. Stevenson (29, 30), who state as the most important achievements of military clinical psychology: (1) the development of abbreviated testing techniques, (2) the development of neuropsychiatric screening devices, and (3) the development of group projective techniques, the term development being used by Hunt and Stevenson to signify perfection rather than truly original invention of techniques. Their summary of the status of clinical psychology in the military may well serve as a summary of the present discussion. They write:

In conclusion it should be stated that the size of the psychiatric case load plus the shortage of trained psychiatric and psychological personnel in the military services has resulted in two characteristics of military clinical practice that differentiate it from civilian practice. These are the stress upon speed, and the stress upon classification and disposition at the expense of therapy. These demands have formed and limited the development of military clinical testing, but within these limitations there has been much healthy growth that should serve as a genuine stimulus to post-war clinical psychology.

(30, p. 114)

An immediate impression of the immensity of the diagnostic problem in the Services and consequently, of the importance of the practice of clinical psychology in the narrower sense distinguished above, may be gained from the following statement made by General Menninger, Chief Neuropsychiatric Division, U. S. Army, covering the overall neuropsychiatric cases (including mental deficiency) in the Army:

In the induction centers, 39% of the total rejections were because of personality disorders, and this figure represents 12% of all the candidates appearing for examination. There were a little over one million admissions to hospitals for neuropsychiatric causes, which represented about 6% of all admissions. (5, p. 59)

General Menninger also points out that 60% to 70% of all neuropsychiatric patients were classified as psychoneurotic rather than psychotic. This figure is significant for clinical psychology especially in terms of the often made distinction between clinical psychology and psychiatry whereby treatment of the mildly maladjusted is regarded as the province of clinical psychology while the psychotic are to be dealt with by psychiatry.

A similar impression of the immensity of the diagnostic problem may be gained from the Navy experience. In this connection, Captain Francis J. Braceland, Chief Neuropsychiatric Division, U. S. Navy, states:

91,565 enlisted and inducted recruits were rejected at the training centers

(Naval) by reason of inaptitude, because of various neuropsychiatric disabilities, which disqualified them from naval service. (5, p. 64)

This figure covers the calendar year 1942 through the first six months of 1945. Captain Braceland like General Menninger emphasizes the extent of the psychoneurotic illnesses (including the psychopathic personality) as compared with the clearly psychotic illnesses. He states that "91% of the psychiatric problem is concerned with mental disorders other than actual insanities. (5, p. 66)

### 3. Rehabilitation Of Veterans

Another major area within which clinical psychology is functioning is that associated with the aftermath of the war, namely, the rehabilitation of veterans. The scope of the problem of returning and readjusting servicemen to civilian life is tremendous and ranges from educational and vocational guidance of veterans through rehabilitation of the physically handicapped to diagnosis and treatment of the mentally ill veteran. The extent of the last mentioned problem, that of the neuropsychiatrically ill veteran, may be realized from the statement by Dr. Daniel Blain, Chief, Neuropsychiatric Division, Veterans Administration, that "over 60% of the entire hospital load of the Veterans Administration in all categories of patients comes under

the head of neuropsychiatric disability." (5, p. 28) The outpatient load is not included in this figure. Dr. Blain also states that "the disability pension lists show neuropsychiatry to account for up to 50% in certain categories of disability. Most of these are outside the hospital, and most of them should be getting some form of treatment." (5, p. 28)

The role of clinical psychology even within the restricted area of veteran rehabilitation is greatly varied, as seen from the content of a recent symposium (31) on clinical psychology in the civilian rehabilitation services. This symposium contains articles describing (1) the psychological services in the Veterans' Administration in connection with the diagnosis and treatment of medically and neuropsychiatrically ill patients, (2) the psychological program in Veterans Guidance Centers in Colleges and Universities carried out in connection with and cooperation with the Veterans' Administration, (3) the program for vocational rehabilitation of the physically disabled veteran carried out by federally sponsored State agencies, (4) the program of employment counseling in the United States Employment Service, (5) the college and university program of reorientation of veterans, and (6) a program for the rehabilitation of the newly blinded veteran.



Another recent Symposium (32) on clinical psychology in the Veterans Administration co-edited by J. G. Miller, Chief, Division of Clinical Psychology, Neuropsychiatric Service, Veterans Administration, outlines the clinical psychology program in (1) a Mental Hygiene Clinic, (2) a Hospital largely devoted to neuropsychiatric patients (The Winter V.A. Hospital, Topeka), (3) a discussion of the overall research program in clinical psychology, and other articles related to the Veterans Administration program. The striking feature of this symposium is the great stress placed upon the improvement of the status of clinical psychology as a science and a profession. Thus, Dr. Miller speaks of the "professional revolution" which is taking place in this connection, the ultimate aim of which is to establish clinical psychology on a comparable basis with psychiatry.

The general principle which seems to be guiding the thinking in the entire Veterans Administration program is that the role of clinical psychology whether in diagnosis, therapy or research is not merely a technical one comparable to that of a laboratory technician. H. M. Campbell (33) elaborates on this principle as follows:

The psychologist is neither a technical (or laboratory) assistant to the psychiatrist, nor is he a consultant on special psychological problems deemed emergent during examination by the psychiatrist or social worker and posed by them to the psychologist for specific



solution. As technical assistant or special consultant, the psychologist unnecessarily restricts his investigation to spheres far short of what he is in actuality able to accomplish. Moreover, he is almost certain, either to arrive at conclusions unwarranted on the basis of his narrow approach, or report only very tentative findings frequently inappropriately utilized by the social worker or psychiatrist. In addition, the particular questions posed by the psychiatrist or social worker may turn out to be not the most crucial. In the interest of contributing to the full limit of which he is capable and of achieving optimal validity, the psychologist considers himself responsible for properly investigating all psychological functions (as distinguished from somatic) which may conceivably have bearing on the case of the patient to be treated. It is in this sense that the psychologist is a collaborator with other professional groups forming the mental hygiene team.

(33, p. 17)

While there is a marked tendency to operate under the assumption that psychology makes its best and greatest contribution in the areas of diagnosis and research, there is growing recognition that psychology has a valid contribution in the area of therapy. The principle of psychiatric supervision is generally agreed upon in this connection, and the requirements relative to adequate training and preparation are always emphasized.

#### 4. Clinical Psychology In Hospitals

Clinical psychology in hospitals is another area within which clinical psychology is becoming defined. In

this area, as in all the areas under consideration in this chapter, many of the problems and issues which are the primary concern of the present study have emerged and will continue to take shape and attain significance.

The highly varied role of clinical psychology within the several areas is a fact already pointed out, so that it is not surprising to find a similar situation in hospitals. There is first the variability that results from the simple fact that there are many types of hospitals within which clinical psychology functions. With a recent Symposium (34) on psychologists' functions in hospitals as a guide for discussion, the following types of hospitals or hospital situations may be listed as constituting the main types: (1) Psychiatric hospitals, sanatoria, or mental hospitals (both public and private); (2) Children's units or divisions of the above; (3) Outpatient or mental hygiene clinics of the above; (4) Neurological hospitals (as pointed out by G. Thallman, (34, pp. 308-311) there are few hospitals carrying this specific name though its functions are found in neuropsychiatric departments of other hospitals); (5) General hospitals (especially in neuropsychiatric departments); (6) Non-psychiatric but otherwise specialized hospitals (both private and public) such as the tuberculosis hospital.

The functions of clinical psychology in hospitals range from the psychometric through the diagnostic to the

therapeutic and also include research activities. The psychometric, classificatory, and diagnostic functions seem to be heavily stressed though the therapeutic and research functions are not omitted from the descriptions of the various hospital situations. As F. L. Wells points out, the types of problem in hospitals requiring the use of psychometrics are broad and varied. Wells writes:

On the one hand, they (the problems) cover the range of mental and somatic diseases including problems of rehabilitation as well as clinical status praesens. On the other hand, they include problems without pathological reference, comparable to those of personnel administration in any considerable business establishment. . . . (34, p. 269)

Two ways of using psychometrics may be distinguished: in the one case, psychometrics are used on a more or less mechanical level with the emphasis on obtained quantitative test scores; in the other case, the uniquely clinical aspects of diagnostic testing procedures are heavily stressed so that testing is not simply on a mechanical level but on a highly skilled, particularized and individualized level. For example, E. F. Kinder (34, pp. 273-280) stresses the clinical skills and techniques required in testing and diagnosing children in a psychiatric unit, especially in relation to the handling and evaluation of the emotional life of these types of children. In this connection, Kinder writes:

In work with emotionally disturbed children it is not a deviation in a specific factor in the test situation, such as vision, hearing or language which needs especially to be provided for. Rather it is relationship to the examiner, the test situation as the child experiences it, and the effect of these upon his performance, which requires special study and understanding. Here the qualitative aspects of the examination not only supplements the quantitative findings but often becomes the most important feature of the results, since the way in which the child meets and deals with the standardized situation may afford clues as to the nature of his problems and the extent of the deviation of his behavior from that which he might normally be capable of. (34, p. 279)

Shakow (35) in an article on the functions of the psychologist in the State Hospital, stresses the same points relative to the distinction between a merely mechanical, or as he puts it, purely technical level of the use of psychometrics and a more clearly clinical or more completely diagnostic level. Shakow finds the latter consists of three aspects:

On examination, this diagnostic contribution is found to be of three kinds: (1) The description of what the patient in his various conditions is like in certain relevant psychological functions, i.e., what he is. (2) The implications which the psychological studies have for therapeutic (educational, vocational, personality, etc.) policy, i.e., what to do. (3) The determination of the effects of whatever therapy may have been used on psychological functions, i.e., the evaluation of what has been done. (35, p. 20)

With respect to the necessity for skillful use and interpretation of tests and the special attitude required in administering them to mental patients as constituting the distinguishing marks of the clinical or diagnostic level, Shakow further remarks:

He (the clinician) must be prepared to make frequent modifications in his devices, since in general they have been standardized on children or other inappropriate groups. He must be prepared to exercise ingenuity in dealing with "uncooperativeness" in determining the results. Because important findings frequently do not come out in quantitative scores, he must be especially sensitive to the varieties and nuances of qualitative response, for it is often in them that the major cues appear. (35, p. 21)

Psychometrics on a mechanical level is characterized usually by a concern with the measurement of intelligence or with the estimation of some more or less abstractly defined trait or ability. Psychometrics on a more clearly clinical level is usually characterized by a concern with total personality, and, consequently, tends to employ the recently developed projective techniques which are directed at a more complete and functional understanding of total personality.

Outside of the realm of psychometrics whether mechanical or diagnostic, clinical psychology is found to play a role in therapy. It is here that the greatest amount of variability exists in the types of function, and here that the least amount of clarity in definition of functions

prevails. The range is from the milder forms of therapy, such as occupational, recreational, and educational therapy, through educational and vocational guidance to the more clear-cut forms of psychotherapy including play therapy.

This lack of clarity and lack of agreement in definition of functions with respect to therapy is seen in the views expressed by the writers in the symposium to which reference is being made. Thus, E. F. Kinder (34, pp. 273-280) speaks about the definite and clear-cut contributions of clinical psychology in play therapy; D. Wechsler (34, pp. 281-285) virtually neglects to speak about therapy in his entire discussion of clinical psychology in psychiatric hospitals and so, it may be inferred, regards therapy as outside the province of clinical psychology; P. Whittman (34, pp. 291-297) speaks only of the role of clinical psychology in the evaluation of the progress of results of therapy through the use of psychometrics; D. Rapaport (34, pp. 298-301) recognizes the possible role of clinical psychology in psychotherapy but stresses the difficulties involved in preparing and training psychologists to be therapists; E. L. Schott (34, pp. 302-307) emphasizes the milder forms of therapy including interviewing and remedial teaching; G. Tallman (34, pp. 308-311) believes that remedial teaching is the only form of therapy which should be practiced by psychologists, and specifically excludes



psychotherapy as being out of place for psychology in a medical set-up (Tallman is concerned with a neurological setting entirely); and M. A. Seidenfeld (34, pp. 313-318) stresses guidance techniques and procedures as being the special province of clinical psychology. It may be added that Shakow (35) in his article on the functions of psychologists in the State hospital definitely includes psychotherapy as a valid and proper area of work for the clinical psychologist. Although Shakow places a great deal of weight on the diagnostic and research functions, he definitely includes therapy as a proper function. He boldly states:

Whether by selection, by training or by both he (the clinical psychologist) is frequently more fitted than the medically-trained person for psychotherapeutic work.  
(35, p. 23)

The role of clinical psychology in hospitals that is most clearly defined, recognized, and accepted by all concerned is in the field of research. Almost all of the writers in the symposium mention research though they do not emphasize it strongly enough to the satisfaction of F. L. Wells who believes research to be not only of prime importance and significance but that it is the realm wherein clinical psychology can make its most distinguished and unique contributions.



## 5. Clinical Psychology In Industry

The general role of psychology in industry as applied to the worker has centered largely around the problems related to the efficiency of the worker as a productive unit. Thus, the functions of psychology have tended to be twofold, (1) those concerned with classification, evaluation and selection through the use of psychometrics of one form or another, and (2) those functions concerned with experimental studies of psychological and psycho-physiological factors generally related to working efficiency.

During recent years, however, there has been developing a new and different interest in the worker which involves an aspect of psychology more clinical in nature. The worker has become a subject of interest and concern not simply as a productive unit but as an individual with personal, human and social values. He is coming to be regarded not simply as a cog in the productive process with simply commodity or economic value, but as a human being whose viewpoints, personal and social problems and values are of great importance. In fact, the importance of the personal welfare and adjustment of the worker is being increasingly recognized and accepted as being vital to his efficiency in the productive process. This is made clear by M. S. Viteles (36) in reviewing a

recent symposium on industrial psychology, where he speaks of the growing concern with interpersonal relations, "as the most significant development in industrial psychology during the past decade." (36, p. 182) He describes this development as "the growing concern of industrial psychologists with the sentiments, feelings, and attitudes of workers, supervisors, and managers and with the interplay of people in the social organizations of the industrial enterprise." (36, p. 182)

H. Meltzer (37), in an article in the symposium reviewed by Viteles, describes the clearly clinical approach to the problems of worker-manager relationships as connected with maintaining and/or increasing productivity while simultaneously promoting the welfare and adjustment of the industrial worker. It is interesting to note that in speaking about the use of psychometrics Meltzer clearly indicates the value of the clinical as distinct from the merely mechanical level of the use of psychometrics. Meltzer writes:

Tests of general and special abilities, if interpreted by an individual without clinical understanding of individuality, who does not use the tests merely as aids in the evaluation of personality organization, can yield distorted results rather than facts about human nature. This introduces an element that makes for continuous inconsistencies and contradictions, which are out of line with realistic evaluations of their usefulness in improving productivity. For realistic work in industry, therefore,

test results without interviewing procedures and personality evaluations by more appropriate techniques can conceal and distort data about personality rather than reveal them. Only a clinical use of tests is justified in industry. It is easy to say that science is interested in prediction and control and that psychology as a science is interested in prediction and control of human behavior. But what will they predict and what control? And where? For what purpose? There are many factors that have to be controlled, and before they can be controlled should be understood, not as such but in dimensions--internal and external, as well as the interplay of both. This shift of emphasis from a test-to-a-man-emphasis, a man-in-a-social-organization-emphasis, can be said to be a clinical approach or a clinical emphasis, the simple reason being that the clinician in practice is interested in helping people in life situations and, when his work is in industry, that still is his function. His job is not to introduce tests for selection or upgrading but to produce or help produce the type of techniques and procedures, arrangements and organization, that help solve the problems of industrial management. (37, p. 172)

A particularly interesting development within industrial psychology that reflects the new emphasis on the welfare and individual adjustment of the worker is counseling in industry. This is interesting because from the point of view of the functions of clinical psychology, counseling represents a form of therapy insofar as it places stress on altering interpersonal relations rather than on diagnosis, classification or selection.

The pioneering work in this field of personnel counseling in industry was done at the Hawthorne Plant of

The Western Electric Company and is described by Roethlisberger and Dickson (38). This work carried out in collaboration with the Harvard Graduate School of Business, evolved as part of an extensive research program in industrial psychology and industrial relations. It may be noted that personnel counseling at the Hawthorne Plant was established on the firm grounds of the results of research rather than on the basis of mere sentiment or whim. In addition, it should be pointed out that personnel counseling, important and significant as it is, constitutes only one aspect of a larger industrial relations program at Hawthorne. The rather clear indication seems to be, as far as personnel counseling in general is concerned, that it attains its greatest value and indeed may only be valuable when it is organized as an integral part of a larger industrial relations program which includes the more usual functions of industrial psychology.

This evaluative judgment seems important to insert here because the enthusiastic growth of personnel counseling in industry appears likely to result in a loss of perspective with respect to its proper role in relation to the whole problem of industrial relations. The present purpose, however, is simply to point to the growth of personnel counseling as a clear and significant example of an application of clinical psychology. The many books on counseling in industry which are beginning to appear

may be taken as a sign of the rapidly growing interest in this new phase of industrial relations. The book by N. Cantor (39), and that by A. Garrett (40) may be cited in this connection, as well as the earlier work by Roethlisberger and Dickson (38). Several of the books recently published, including those by Cantor and Garrett, seem oriented to meet the almost critical need and demand for the development of personnel counseling in industry, but they seem to be directed at non-psychologically and non-clinically trained people in an effort to provide them with a minimum understanding of the essential principles of counseling. It would appear from this that clinical psychology as a profession has neglected, for the most part, the field of personnel counseling in industry and has failed to see it as a possible and valid area within which there is a strong need and demand for its services. This seems to be the situation notwithstanding the general growth of interest in interpersonal relations noted by Viteles. Perhaps, this represents merely a temporary lag, and personnel counseling in industry may soon come to be regarded as a challenging area for clinical psychology which should be developed in a manner comparable to some of the other areas.

## 6. Clinical Psychology In Guidance and Counseling.

The area designated by the term guidance is not well delineated. Originally, it was used in a restricted sense to refer to the activities carried on in the clinics first established in 1922 by the National Committee for Mental Hygiene and the Commonwealth Fund. G. S. Stevenson and G. Smith (41) trace the history of these clinics until 1934 and give an excellent account of the philosophy upon which they are based. P. H. Cook (42) gives a more recent and somewhat broader account of child guidance with respect to its varied theoretical background and the variety of techniques it employs. H. L. Witmer (43) gives a recent summary statement of the nature of child guidance in which she cites much of the literature (including her own earlier work) related to its history and theoretical background.

The child guidance clinics established under the National Committee for Mental Hygiene were dominated by psychiatry so that the original concept of guidance was formulated largely from a psychiatric viewpoint. This tended to be the case even though the principle of the clinical team as composed of psychiatrist, social worker, and psychologist was early formulated ostensibly to emphasize the integral quality of the functions and contributions of each clinic member. The consequence of psychiatric domination on the status of clinical psychology is



that it came to be defined largely in terms of diagnosis. This does not necessarily imply that the psychologist was simply a psychometrician, for, from the beginning it was recognized, at least theoretically, that diagnosis involves something more than psychometrics. Stevenson and Smith make this clear in the following statement:

One of the distinctive qualities of the clinic has been their refusal to rely on the naked psychometric test as a significant piece of information about the child. The staff psychologist chooses from the ordinary tests those which seem most appropriate, and in some instances has contributed toward their refinement or standardization, but normally the tests are set in a frame of observation in which the behavior and attitude of the child during the interview are carefully studied and an effort is made to discover the general set of his mind. The psychologist interprets his test results so far as possible not only with reference to general norms of unselected cases (the intelligence quotient), but also with reference to the probable intelligence of the child's family, brothers, and sisters, the neighborhood, and his class in school. The psychological study is thus an appraisal of the child's mental assets and liabilities, his educational capacities, his special abilities and disabilities. In cases where emotional or extraneous factors throw doubt on the validity of a single examination, the child is restudied as often as seems necessary. (41, p. 85)

Though clinical psychology was not defined in terms of mechanical psychometrics, but functioned on the level of clinical diagnosis and research, the therapeutic functions were largely reserved for psychiatry, and for psychiatric social work under the direction of psychiatry. P. H. Cook (42), however, notes that there is a growing tendency to



broaden the scope of clinical psychology by including therapy within its range of functions, and believes this to be a justifiable tendency. He writes:

Provided the psychologist has the necessary training and personal qualifications, and is working in a clinic in close co-operation with the psychiatrist and psychiatric social worker, there is no reason why he should not engage in therapy. It is impossible to state arbitrarily who should and should not undertake therapy; much will depend on the qualifications of the different members of the clinical team, on the nature of the problem presented, and on the actual case load already being carried by the various workers. (42, p. 34)

Today the term guidance tends to have a broader application in that it is used to describe clinical activities not necessarily limited to those carried out under the National Committee for Mental Hygiene. In general, clinical study concerned with diagnosis and treatment of personality (in its widest sense) and behavior problems of children and of their parents may be designated as guidance. The concept is no longer exclusively psychiatric so that clinical psychology has acquired a broader meaning. The clinical work done in various types of educational institutions is often described as being within the realm of guidance and in terms of a broadened view of the functions of clinical psychology. The school psychologist, for example, may function in terms of guidance and in terms of a broadly conceived clinical psychology as applied to

an educational setting. P. M. Symonds (44) recently describes the role of the school psychologist in essentially these terms. He writes:

A school psychologist is a psychologist in a school--that is, one who brings to bear on the problems of the school and its administrators, teachers, and pupils the technical skill and insight which the science of psychology can provide. The school psychologist is a specialist in human relations, and by virtue of his understanding of the principles of motivation, learning, and individual differences, and his skill in applying this knowledge to educational problems, occupies the position of a technical expert in the school similar to that of the engineer in an industrial enterprise.

(44, p. 173)

When the school psychologist first started to operate about twenty-five years ago, his activities were largely limited to mental testing. The present trend according to Symonds, however, is to conceive of his functions as including those related to both therapy and diagnosis.

The concept of guidance is even broader than has thus far been indicated. Educators conceive of guidance as an integral aspect of present day public education whether on a primary, secondary or college level. According to a recent statement of a group of educators:

Guidance is the educational process that helps an individual make the best possible life adjustment. (45, p. 15)

In writing of the scope of guidance, these same educators state:

Various authorities in the field of guidance are agreed today that certain aspects of guidance are necessary to successful adjustment to living. All agree that educational, vocational, and social-civic guidance is indispensable; nearly all agree on including, in addition, personal and economic guidance, and guidance in leisure time and recreational activities, health, and home relationships. (45, p. 16)

The following activities are then listed as characteristic of all good guidance programs:

1. Study of the individual through observation, interviewing, and testing to determine:
    - a) Intellectual capacity
    - b) Achievement
    - c) Personal characteristics
    - d) Interests and aptitudes
    - e) Social adjustment
    - f) Home environment
  2. Cumulative reporting of pertinent data about the individual
  3. Maintenance of adequate health facilities
  4. Orienting the student to the activities and policies of the school
  5. Adequate educational and vocational guidance
  6. Providing opportunity for help and advice on personal problems, particularly clinical diagnosis of emotional and attitudinal disturbances
  7. Instruction in occupational information.
- (45, p. 16)

Counseling actually does not refer to an area in the sense of a place or setting in which clinical psychology has developed since it is a method which cuts across most of the areas mentioned in this section of the study. It is mentioned here, however, because it is closely associated

with guidance and is the aspect of guidance particularly suited for the development of clinical psychology. The group of educators cited above, speak of counseling as "the heart of guidance" and define it in very general terms as "a discussion or conference between an individual with problems and an older more experienced person who attempts to help him solve them." (45, p. 18) They further define counseling as:

the personal and direct help given the student through conversation, interchange of ideas, and careful questioning. In other words, counseling may be defined as the information, advice, and assistance given to a counselee by a counselor who is constantly aware of the counselee's significant interests, abilities, and personal situations. (45, p. 20)

While these educators recognize that counseling requires specialized knowledge and skills and may be a highly technical procedure, they tend to conceive of it in a loose manner as compared with the way in which it is likely to be conceived by psychologists. C. R. Rogers (46), for instance, conceives of counseling as a form of psychotherapy, which is highly technical and systematically developed. Counseling thus becomes more clearly recognizable as an aspect of clinical psychology rather than of education; an aspect which has been strongly influenced by education and is often formulated in an educational setting to meet educational needs, but from the point of view of its basic principles and techniques it seems a part of clinical psychology.

## 7. Clinical Psychology In Relation To Delinquency And Crime

The history of clinical psychology in relation to delinquency and crime dates more or less from the early days of intelligence testing when it was believed that there was a direct relationship between low intelligence and crime. The psychological work in such a setting tended to be limited largely to mental testing and to research designed to discover the relationship between intelligence and crime as measured by tests of intelligence.

Present day clinical psychology in juvenile or adult penal settings usually functions within the framework of a clinical team (composed of psychiatrists, social workers and psychologists) often referred to as the classification board or committee. The traditional task of such a board or committee is almost entirely, as its name implies, classificatory and diagnostic so that it is not surprising to find clinical psychology defined in terms of psychometrics or diagnosis. It is also extremely important to note that professional clinical work of any kind in penal settings is hampered by the atmosphere of punishment and harsh discipline which negates a treatment atmosphere. This is a reflection of the prevailing social pressure which demands punishment rather than treatment. Nevertheless, there is a growing tendency for the classification board to reach beyond its traditional limits and to view classification

and diagnosis as only preliminary measures for the more significant task of treatment. Under such a regime the role of clinical psychology becomes defined within the framework of a guidance or rehabilitation program the objective of which is to meet individual needs on the educational, vocational, and personality levels. Its functions become psychometric, diagnostic and therapeutic and so resemble those in other areas such as hospitals, guidance clinics and schools. The delinquent or criminal is regarded as a special type of client or patient who is comparable to other types of clients or patients in a significant way and who therefore requires essentially similar methods and techniques for diagnosis and treatment. Clinical psychology in relation to delinquency and crime seems but a special application of a generic discipline.

A recent publication edited by R. M. Lindner and R. V. Seliger (47) contains a wealth of material related to the role of clinical psychology in penal settings which may be referred to by way of elaboration and substantiation of the generalizations offered above. There are, for example, articles on the operation of and functions of the classification clinic, on the use of psychometric procedures, on various aspects of diagnosis and therapy of delinquents, all of which are specially significant. An article by R. P. Knight on "The Meaning Of Punishment" (47) offers an excellent though concise statement of the



psychological significance of punishment. Knight shows that punishment grows out of the most primitive layers of personality which meet displays of aggression with counter-aggression and retaliation and so defeat their purpose in that a vicious circle of further aggression and retaliation is set up. He makes an extremely important distinction between punishment and discipline showing that discipline means education and is positive and constructive. It involves creation of positive forces in the personality and does not necessarily require the use of punishment. Discipline is the essential requirement for civilized life but punishment is a primitive and negative form of discipline.

These ideas lead up to the present day trend of thinking about the delinquent and criminal in terms of education and treatment rather than of punishment. Knight's statement of the objectives of such a treatment program epitomizes the modern enlightened attitude:

(1) The protection of society from the aggressions and depredations of the offender for as long a period as was deemed necessary, after scientific study and continued scientific observation. . .

(2) The attempt to salvage and rehabilitate every offender by fitting him into a program of work, recreation, psychiatric treatment (if indicated), reeducation and all the influences that could be brought to bear on him to rehabilitate him for re-entry into society. This would make every prison a huge



psychiatric hospital with enough divisions to provide all appropriate activities and segregation advantages necessary in a psychiatric hospital. . . (47, p. 675)

Within the framework of such a program, it becomes possible for clinical psychology to be developed to the limit of its potentiality. In fact, whatever contribution clinical psychology can offer toward the solution of the tremendous problem posed by the critically high incidence of delinquency and crime, can be realized only under the kind of program proposed by Knight.\*

In concluding this part of the study on areas, it is necessary to recall that no attempt was made to present an exhaustive survey of all the specific areas in which clinical psychology in any of its many aspects is found in operation. One significant area which perhaps should have been dealt with at some length because of its historical importance is that concerned with mental deficiency. However, many of the observations made in connection with the hospital area are applicable to the area of mental deficiency in so far as the development and status of clinical psychology is concerned, so not too much has been lost by the omission.

---

\* In actuality, however, clinical psychology plays a relatively minor role in prison systems today. R. Corsini, in a recent article (Functions of the Prison Psychologist; J. CONSULTING PSYCH., 1945, pp. 101-104) states: "Some two-hundred thousand people at this moment are confined in the U.S. in correctional institutions. . . . According to a recent estimate there are eighty psychologists employed by correctional institutions, although there are certainly at least twenty more who are not members of professional groups. The ratio is therefore, for the country as a whole, one prison psychologist for every two thousand prisoners. . . ."

## Chapter II

### SOME BASIC PROBLEMS REGARDING SCIENCE AS RELATED TO THE DEFINITION OF CLINICAL PSYCHOLOGY

#### 1. General Plan Of Chapter

In order to arrive at a more complete understanding of the nature of clinical psychology, and to formulate as comprehensive a definition as possible with respect to the subject matter, methods, techniques, aims and objectives of clinical psychology, it is necessary to inquire into some of the problems regarding the nature of science, natural science, social science and applied science. It is inevitable that any attempt to define clinical psychology will involve direct reference to these concepts so that clarification of them becomes essential. What does it mean to say that clinical psychology is a science, or a natural science rather than a social science, or a pure science rather than an applied science? What is involved in the choice of any of these concepts in so far as the attempt to characterize or define the nature of clinical psychology is concerned? These are questions which prompt inquiry here.

The purpose here is to point the way toward some answers to these questions through an inquiry into the conceptual background of science. Controversial issues

will be dwelt upon to show the magnitude and wide ramifications of the problems and to indicate some of their implications. No effort will be made to maintain one line of argument or one position with respect to them, though some tentative conclusions related to clinical psychology can be sifted out of the various lines of thought.

## 2. Recent Trends Toward A General Definition Of Science: Some Ideas Of Rudolf Carnap and John Dewey

Science, as a conceptual framework, is by no means a simple matter upon which there is readily obtained agreement as to its nature and definition. In the nineteenth century, there appears to have existed considerable agreement about what science was, but since then science has been complicated by recent discoveries such as those growing out of relativity and quantum physics. These complications precipitated what is often referred to as the "crisis in science" which in turn, has led to a good deal of thinking in the direction of clarifying and reevaluating science. There is a widespread interest in the "philosophy of science," an interest which is most active in respect to the historically more recent sciences such as psychology.

Among the important results of the recent sophistication concerning the nature of science is the realization of the necessity for a general definition of science as distinct from a definition based upon a specific

science or a specific scientific methodology. At the outset, it should be noted that it is possible to go too far in the direction of formulating a general definition of science as Forest Ray Moulton and Justus J. Schiffers seem to have done when they arrive at the statement that, "no single definition of science has ever been accepted, we describe science simply as the sum of the things and thoughts of its practitioners." (48, p. vii) Such a definition of science appears to be so general and all-inclusive as to become meaningless.

It is profitable, however, to examine Rudolf Carnap's (49) ideas in this connection as representing a more feasible way of regarding science in general terms. He uses the term science in its widest sense to include all theoretical knowledge in both the natural and social sciences no matter whether such knowledge is based upon special procedures or common sense. Science, for Carnap, is defined as being any activity that is carried out to know something. The only sort of thing that Carnap excludes from science as so defined is that which is concerned with or made up of emotional expression, or commands. Activities represented in poetry and music, for example, are excluded as not being part of science.

From this general definition, Carnap can proceed to differentiate the specific sciences. Thus, physics becomes distinct from biology, or the physical sciences

become distinguished from the biological sciences in that the former deal with non-organisms while the latter deal with organisms. Physical laws, however, apply to all nature, both organisms and non-organisms. Biological laws apply only to organisms.

The biological sciences, in the widest sense, may be divided into the biological sciences in a narrow sense and into the psychological and social sciences. The psychological and social sciences deal with:

. . . the behavior of the individual organisms and groups of organisms within their environment, with the dispositions to such behavior, with such features of processes in organisms as are relevant to behavior, and with certain features of the environment which are characteristic of and relevant to the behavior, e.g., objects observed and work done by organisms. (49, p. 47)

Biology, in the narrower sense of what is usually referred to as constituting biology proper, is difficult to distinguish accurately and completely from what is called psychology and from the social sciences. Carnap raises this problem of differentiation and offers some possible solutions:

Which processes in an organism are to be assigned to the second field (psychological and social sciences)? Perhaps, the connection of a process with the processes in the nervous system might be taken as characteristic, or, to restrict it more, the connection with the speaking activities, or, more generally, with the activities involving signs. Another way of characterization might come from the other direction, from the outside, namely, selecting the processes in an organism

from the point of view of their relevance to achievement in the environment (Carnap refers to the work of I. Brunswik and Ness in this regard). There is no name in common use for this second field. (The term "mental sciences" suggests too narrow a field and is connected too closely with the metaphysical dualism . . .) The term "behavioristics" has been proposed. If it is used, it must be made clear that the word "behavior" has here a greater extension than it had with the earlier behaviorists. Here it is intended to designate not only the overt behavior which can be observed from the outside but also internal behavior (i.e., processes within the organism); further, dispositions to behavior which may not be manifest in a special case; and, finally, certain effects upon the environment. (49, p. 48)

It is clear that exact distinctions among the sciences upon which common agreement may be obtained are difficult to make, and this is particularly true with respect to the biological and social sciences including psychology as pointed out by Carnap. This state of affairs is probably a reflection of the lack of agreement about science in general.

Carnap's primary purpose in the above mentioned essay is to lay the logical foundations of the unity of science. It is important to note that the search for the unity of science, as it is carried out by Carnap (and, probably, by the others in the unity of science movement) is not concerned with questions of ontology and reducibility to absolutes but rather with reducibility in terms of logic. It is concerned with the logical relations



among the sciences and not with creating one single science in any narrow sense. Unity is sought in terms of an analysis of the logic of the statements made in science. There is, at present, no unity in the laws of science, though Carnap believes the aim to achieve such unity of laws is a valid and attainable one, that is, attainable in the future. It is of interest to note that R. H. Wheeler's (50) organismic laws aim at achieving the unity of science on a general level. The significant point to be stressed in relation to the present problem, however, is that a science like psychology need not be formulated according to the specific pattern set down by the physical sciences or by any other particular science. Indeed, it must not be so formulated at the present stage of science. The Watsonian behaviorism, mentioned by Carnap in the above quotation, is an example of a psychology formulated in terms of and patterned after the natural science of the late nineteenth century and early twentieth century, on the assumption of its absolute validity as science. Association psychology, in general, is patterned after a mechanistic type of science in emulation of the natural science of its day.

To escape the tendency to pattern psychology rigidly after the physical sciences, it becomes necessary to define science in general terms, at least, in terms which are broader than those upon which Newtonian physics,



for example, is formulated. John Dewey (51) has expressed a view of science which may be considered an example of a view that meets the requirement with respect to a general definition of science. He believes, to follow one of his fairly recent statements, that the scientific method is not confined to scientists but may be used by a wide variety of people. It may be used, says Dewey, by all who use intelligence in choice of means and adaptation of means to ends, in contrast to those who rely on routine, guesswork, dogma, and prejudice. Accordingly, Dewey defines the scientific attitude as:

the will to inquire, to examine, to discriminate, to draw conclusions only on the basis of evidence after taking pains to gather all available evidence. It is the intention to reach beliefs, and to test those that are entertained, on the basis of observed fact, recognizing also that facts are without meaning save as they point to ideas. It is, in turn, the experimental attitude which recognizes that while ideas are necessary to deal with facts, yet they are working hypotheses to be tested by the consequences they produce. (51, p. 31)

### 3. The Ideas Of C. W. Morris On The General Definition Of Science

Another way in which to view science for the purpose of arriving at an understanding of its general meaning and significance, is that proposed by C. W. Morris (52) in a recent book. He considers science, in one of its most

important aspects, in terms of it being a kind of language. This is similar to the proposal of Carnap, but Morris seems to state the case in a clearer, more complete way. Morris regards science as a particular type of specialization of language derived from common everyday language. He speaks of science as being one of 16 major types of discourse, classified in terms of mode of signifying and use.\* This is an approach based upon an analysis of signs, language, and behavior in general which Morris develops in his book. He does not attempt at present, however, to formulate a strict definition of science as a type of discourse. Nor, for that matter, does he attempt a strict definition of any of the other specializations of language, or major types of discourse. He simply speaks of science as being illustrative of one of the major types of discourse without attempting a thorough definition.

The specialized type of discourse exemplified by science is called by Morris, the "designative-informative" discourse. This means that science uses the designative mode of signifying as exclusively as possible of the other modes of signifying, i.e., exclusive of the appraisive, the prescriptive, or the formative modes. The main task of

---

\* Mode of signifying is a basic term in Morris' science of signs (semiotics) and is defined in the Glossary (52, p. 35) by Morris as: "A differentiation of signs in terms of the most general kinds of significata. Five modes of signifying are distinguished (identificative, designative, appraisive, prescriptive, and formative), and signs signifying in these modes are called respectively, identifiers, designators, appraisors, prescriptors, and formators."

science is to inform rather than to evaluate or incite, as is the case in some of the other types of discourse. Morris writes in this connection:

As science advances, its statements become more purely designative, more general, better confirmed, and better systematized. Scientific discourse is therefore made up of those statements which constitute the best knowledge at a given time, that is, those statements for which evidence is highest that the statements are true. Science is especially concerned with the search for reliable signs. The goal to which science moves is a systematized body of true statements about everything which has occurred or will occur. But since at each moment the selection of statements for admission to science is dependent upon evidence that the statements are true, the selection will vary as new evidence is obtained, and so the scientific discourse of any one time may differ greatly from the scientific discourse of another. (52, p. 126)

Morris further points out that if the above description of science is a true one, it follows that the statements in science must be confirmable. However, he recognizes that this minimal criterion of confirmability must be applied with wise tolerance in actual practice. In making such a qualification about the criterion of confirmability, Morris is particularly thinking of those sciences which are not so far advanced, namely, the biological, the psychological and social sciences. In this regard he notes that relatively unconfirmed statements or poorly confirmed statements which are likely to be found in the less advanced sciences are called hypotheses, while

the well confirmed statements usually found in the physical or natural sciences are known as laws. The implication of this for clinical psychology seems to be that if it be conceded that clinical psychology is in an early stage of development wherein its statements are only poorly confirmable and partake of the nature of hypotheses rather than laws, then it may be considered a science but only with the definite qualification that it be understood as a science in an early stage of development. In other words, clinical psychology may be considered as a science provided science is understood in a general sense.

While it is of unquestionable value to define science in a general way: as suggested by Carnap, Dewey and Morris, it is also important, as indicated by Morris's analysis of science, that it be defined quite specifically in relation to other modes of discourse which are, in turn, also specifically defined as excluding science or scientific discourse. The definition of science according to the analysis of Morris is general in the special sense that it cuts across the conventional boundary lines of the separate sciences and thus moves in the direction of the unity of science. His definition of science is simultaneously specific in that it limits what should be included as science and what should be excluded as belonging to some other type of discourse.

#### 4. The Non-scientific Realms Of Discourse As

Analysed By G. W. Morris

#### And Their Relation To Clinical Psychology

Morris does not depreciate or discredit the various other types of discourse which are outside the realm of science such as the religious, the moral, the philosophical and the metaphysical. He points out that his analysis of the various types of discourse avoids the crude separation of them into those which are scientific and valid and those which are unscientific and therefore invalid. His analysis is intended to demonstrate in a sympathetic manner the unique importance of each type of discourse. It attempts to indicate or to suggest the inter-relationships of the varieties of discourse and to respect their unique identity, function, and value. In this connection, Morris writes:

Complex human behavior needs all of these types of discourse, but it is ill served when one of them claims for itself an adequacy and importance which it does not possess. Any actual document or speech may, of course, be composed of all kinds of signs and used for the fulfillment of all the main purposes we have distinguished. (Morris includes virtually the entire gamut of purposes in his analysis). But clarity as to the major types of discourse is essential if language is to become the magnificent instrument of man's total life which its nature permits it to be.

(52, p. 152)

The following inference may be drawn from this view with respect to the problem of defining clinical

psychology as a science: Clinical psychology deals with complex human behavior in many of its aspects so that clinical psychology must make use of many if not all of the possible types of discourse including scientific discourse. Examination of the language used and the statements made in clinical psychology reveals that many if not all the types of discourse are used at one time or another. This will be illustrated below and in several other places throughout this study. It is believed, moreover, that many of the types of discourse analyzed by Morris throw a great deal of light on the nature of clinical psychology, for the various aspects of clinical psychology become clearly revealed as various types of discourse.

One aspect of clinical psychology other than the strictly scientific which is revealed by a type of discourse analyzed by Morris is the technological aspect. Technological discourse is described as, "discourse which prescribes actions for the purpose of informing interpreters how to attain certain goals." (52, p. 143) It is, in short, "prescriptive-informative" discourse. In simple language, it is a "how to" discourse and as such is not at all concerned with the nature of the goals but only with how to attain the goals what ever they may be.

Technological discourse is deeply concerned with questions of adequacy and efficacy of techniques as means of accomplishing certain ends. It is clearly related to



scientific discourse, but it is thereby not identical with scientific discourse. Morris writes, on this point:

Scientific knowledge acts as a constant source of control for existing techniques and it is often generative of new techniques, yet technological discourse is not scientific discourse and it is not controlled by it alone. To say that it "should" be is to speak prescriptively, and it is only one prescription among others. Factually, the most we can say is that technological discourse does normally vary with increasing knowledge of the relativity of the techniques prescribed. In a culture in which science plays a prominent role, science will undoubtedly exercise increasing control over the accepted technological discourse of that culture. But much of such discourse is highly resistant to scientific control and cannot be simply condemned on that basis alone if we are genuinely concerned with an analysis of the way signs operate in behavior. Indeed, it is certain that many of our practices for which we invoke the sanctions of science--including some techniques in contemporary science itself--will be regarded by later generations as magical. This is a special instance of the general point that a person may be mistaken as to the type of discourse which he is producing or interpreting.  
(52, p. 144)

It is interesting to note what Morris says regarding the distinction between magical and technological discourse since reference is made to it in the above quotation and it has some bearing on clinical psychology. Magic is a sort of technology, in that it is prescriptive and informative but it is a technology in which the efficacy of its techniques is undemonstrated with respect to the attainment of the goals that are involved. The further point is made that it may be very difficult at a



particular time in the development of a culture to say what is magical and what is more strictly technological, and that they often overlap. It may be warranted to state on the basis of this observation that the technological achievements in clinical psychology are best viewed with humility, and that the achievements falling within the realm of magic to-day such as those often regarded as instances of quackery, should be viewed with tolerance insofar as techniques are concerned. The aim of clinical psychology should be to perfect techniques which now have the status of being magical to the point where they become more acceptable in the strict sense of technological. This attitude toward the techniques associated with quackery is similar to W. Stern's viewpoint, who, as noted earlier, thinks that techniques in the realm of quackery may be developed into becoming acceptable and valid.

Clinical psychology partakes of technological discourse insofar as it may be concerned with prescribing actions for the purpose of informing people how to attain some goal without, for the moment, considering what that goal might be. Thus, for example, it may be stated that the part of clinical psychology which is concerned with the aspect of therapy which deals only with techniques of handling, influencing, or controlling and guiding people considered for the sake of analysis apart from the aims and

goals of therapy, is technological in Morris's sense. On a more general level, clinical psychology may be considered to be technological insofar as it is concerned with developing and perfecting any or all of its techniques (including psychometric and therapeutic techniques) and insofar as it employs any of its instruments and techniques regardless of ultimate goals and objectives. In the nature of the case, a good deal of the work and activities in the whole field of psychometrics tends to be technological, while the field of therapeutics except in those aspects noted above, tends to fall outside the strictly technological. Moral discourse is another type of discourse analyzed by Morris which reveals a significant aspect of clinical psychology. Moral discourse, according to Morris, is "appraisive-incitive." It "appraises actions as favorable (or unfavorable) from the standpoint of some group, and aims to incite (or inhibit) these actions. . . ." (52, p. 138) Morris admits that his moral discourse is somewhat narrowly conceived in that it takes little account of discourse which is usually thought of as moral, but is classified by him under other types of discourse such as the critical, or the religious. His conception is based upon what he regards as the central differentiating element of moral discourse, namely, the appraisal of actions in terms of group welfare, as shown in this passage:

appraisals made of oneself or others in terms of what is conducive to group welfare when incitive in aim, constitute moral discourse. The term "ought," so common in moral discourse, is (when a moral "ought") evidence of the dual appraisive and incitive character of moral discourse, for "ought" signifies some action that is positively appraised, and is used in contexts which make clear that the user of the sign is endeavoring to incite the action in question.

(52, p. 139)

In so far as clinical psychology is concerned with the welfare of the individual in terms of his inter-relationship with the group and its welfare, it falls within the realm of moral discourse. The full significance of this point will be developed in the section of the present thesis devoted to the problems of clinical psychology as related to ethics.

## 5. The Issue Of Quantifiability As A Requirement Of Science

In order to clarify further the problem of understanding the extent to which clinical psychology may properly be regarded as falling within the realm of science, it is necessary to introduce some further considerations concerning the general nature of science. Closely allied to the criterion of confirmability as being in some degree a requirement for science, is the requirement of quantifiability. A. N. Whitehead (53), for example, indicates that science must be quantitative rather than qualitative in that it must deal with abstractions which are related

in quantifiable ways as in mathematics. Science, Whitehead believes, must measure rather than simply classify after the manner of Aristotle, though classification is admittedly the first step in science. The requirement of quantifiability has been and still is a very difficult one to fulfill in the case of psychology and of all the social sciences. The work of K. Lewin (54) and that of C. Hull (55), however, represents attempts to formulate a psychology that meets the requirement of quantifiability with respect to its data. Certainly, it must be granted that such efforts might ultimately lead to a science of psychology which meets the requirement of quantifiability.

Leaving aside detailed considerations of the various types of quantification, or various levels of quantifiability, it is, at present, a legitimate and relevant question to ask whether sciences which deal with human or social data can be validly formulated in accordance with the requirement of quantifiability. P. H. Knight raises this question and takes the definite stand that the social sciences cannot be validly so formulated. He writes:

The effort to analyze and to measure-- especially to find quantitative correlations between antecedent and consequent, which is the meaning of causality in science-- encounters at the outset the difficulty that there simply is no real measurement of distinctively human or social data. It is doubtful whether these phenomena should ever be called quantitative, so different

must be the meaning of the term from that which it has in connection with physically objective magnitudes or variables. Human and social phenomena unquestionably present differences of degree. But in the nature of the case these differences can only be estimated, not measured. The nature of measurement is illustrated by the single case of thermometry. It is not men's feeling of temperature which is measured, but some physical phenomenon which, as we learn by a complicated theoretical analysis of experimental data, corresponds in some way to the feeling of heat and cold. But it does not correspond at all accurately, or measurement would not be called for, or would lose its meaning. What is called measurement in the social sciences, including psychology, is the averaging of estimates, and the use of the term measurement is a misnomer.

(57, p. 328)

Knight's comments about measurement are especially relevant to the problem of measurement and psychometrics in clinical psychology. This topic will be given more detailed discussion at another place.

#### 6. The Problem Of The Distinction Between Natural And Social Science--The Position Of F. H. Knight

The issue of quantifiability seems to be part of a larger problem, namely, that of the distinction between natural and social science. Though this problem was touched upon earlier in the discussion of the ideas of Carnap, Dewey, and Morris, here it will be considered more specifically and widened in scope by presenting the views of F. H. Knight. As is evident from the quotation above, Knight opposes the position that there is or should

be a strict parallelism between the natural and social sciences. He does so on the ground that there exists a vast difference in the whole nature of the subject matter of these two forms of science. In brief, he is opposed to positivism in social science as well as to instrumentalism and pragmatism.

Knight believes that the social sciences must rest on a different basis than the natural sciences because in the social sciences the knower and the known are identical, whereas in the natural sciences they are external to each other. Natural science deals with inert objects of nature, while social science deals with Man as he views himself, and as an infinitely heterogeneous, variable, unpredictable being. In addition, the sorts of problem dealt with in social science involve interpretation which, in turn, involves the problem of the relation of motive to action.

Further, he takes the position that Man, as the subject matter of the social sciences, must be interpreted "in terms of a highly pluralistic system of conceptions or categories." (56, p. 330) Man, that is, exists in terms of, or as part of several different sorts of reality, such as the physical, the biological and the psychological. Man cannot, therefore, be understood simply in terms of one sort of reality, rather, Man must be described in terms of at least a half-dozen fundamental



kinds of entity or being, as Knight enumerates in this paragraph:

He (Man) is (a) a physical mechanism; (b) a biological organism, with characteristics extending from those of the lowest plant to the highest animal in the biological scale; (c) a social animal in the traditional sense; (d) a problem-solving individual in the economic sense, an economic Man; (e) a problem-solver at the higher level of critical deliberation about ends; (f) a social being in the sense of free-association of individuals with characteristics (d) and (e). (He may also to some extent be a social animal, in the proper instinctive sense; but, if so, it is to such a limited degree that for the present purposes it may be left out of account). (56, p. 341)

Positivistic, or strictly mechanistic, science can deal with Man only as he falls within the first three types of reality mentioned in the quotation. The issue is stated by Knight, in another place, especially as it relates to the problem of understanding Man as a valuating being in scientific terms. Knight states:

A strictly scientific discussion of general world problems leads inexorably to fatalism, to a mere question of power, to the relegation to a land of dreams of any ethics which involves questions of another sort than that as to which of two forces is the greater in magnitude. The question at issue must be clearly recognized to be precisely this: whether the logic of science itself is universally valid; whether there is or is not a realm of reality which is not comprehended in factual categories and describable in terms of definite meaning combined in propositions subject to empirical verification. . . .

(57, p. 69)



Knight's position with regard to the distinction between natural science and social science in some ways involves a denial of the validity, if not the possibility, of social science in the historical meaning of that term which connotes an application of natural science methodology to social and human content or subject matter. Knight's view leads him to the belief that art presents an equally if not more valid methodology for the study of human and social phenomena. This is seen in the following statement:

Some rather obvious restrictions in outlook which arise from giving too predominant a place to science may be mentioned at this point. A scientific atmosphere obscures if it does not eclipse a considerable part of the field of values. It centers attention on the results of activity, weakening or destroying the value of the process. In addition, it emphasizes the quantitative aspect of the result which can be treated scientifically as against the qualitative or aesthetic aspect which cannot . . . .

(57, p. 107)

As far as clinical psychology is concerned this raises the question of the role of art in clinical psychology, a question which will be discussed later on, but here it is important to note that Knight does not reject science entirely notwithstanding his strong arguments in favor of non-scientific or artistic modes of understanding human behavior. Thus, Knight admits that scientific study of psychology is better than a common sense approach because certain types of scientific

prediction can be made. He further believes that statistical laws are valuable and valid ways of understanding human behavior provided that they are interpreted as being very elemental laws which deal with very simple aspects of behavior. In another sense, scientific laws in the social sciences can have a meaning and validity but only on a very general and abstract level. The laws can only deal with abstractions and can only express abstract relationships. It is in this sense that Knight is willing to concede that there is a "science of economics" and presumably also a science of psychology.

It is interesting to note that Knight's position, though ostensibly in direct opposition to positivism, turns out to be not too different, in one way, from the position of Morris as discussed earlier.\* For, Morris provides for the validity of sixteen major types of discourse including the scientific type, and does not attempt to maintain the universal and exclusive validity of science and scientific method in respect to the understanding and control of all aspects of human behavior, as, it must be admitted, some of the earlier, less sophisticated, positivists seem to have done. Otto Neurath (58), another representative of the modern positivists or scientific empiricists, also

---

\* C. W. Morris is a prominent member of the logical positivists or scientific empiricist school of thought.

seems keenly aware of some of the points Knight makes and takes them into account.

### 7. The Views Of Otto Neurath Relative To The Distinction Between Natural And Social Science

It may first be noted that Otto Neurath comments on the false notions social scientists sometimes have about the nature of physical science. He writes:

Social scientists sometimes think of physics and astronomy as of an El Dorado of exactness and definiteness, and they assume, frequently, that in this field any kind of contradictions are fatal to hypotheses. Of course, scientists in all sciences try to fit hypotheses into a cluster of other hypotheses, observation-statements, and other accepted statements. But certain defects, e.g., well described contradictions, do not always induce scientists to discard a hypothesis. They may maintain that this hypothesis is often useful and that there is no other more attractive hypothesis. . . .

(58, p. 25)

Thus, Neurath believes that negative instances may not always be taken to rule out a hypothesis. Newton's laws, for example, are still regarded as valid in certain areas even though they are contradicted by the findings in relativity physics. Neurath further points out that the flexibility and adaptability of the data dealt with in the social sciences reduces predictability. That is, predictability is limited in the social sciences by the very fact that making a prediction may alter or negate entirely that same prediction. This may be illustrated by an example

from present day economic problems: If an economist predicts a depression that very prediction may alter the coming of a depression or may hasten the coming of the depression. On the other hand, if an astronomer predicts the course of a comet, that course will not thereby be altered. In clinical psychology the psychologist's statement to a client to the effect that the client has a certain characteristic or trait, or that he is reacting or will react in a certain way, may well serve to alter the behavior of the client in such a way as to make the predictive statement of the psychologist false.

Neurath's general position with regard to the problem of defining social science as distinct from natural science, represents an attempt to define social science in terms of methodological considerations and principles which are based upon scientific empiricism, or logical empiricism and physicalism. The content of social science is defined as extremely broad and all-inclusive. All forms of group behavior, whether plant, animal or human are included. The principle of physicalism required only that those propositions are valid for science which have a spatio-temporal reference. The essential requirement of scientific empiricism seems to be that the analysis of propositions in science must be carried out by means of, or in terms of observation-statements. The aim is to be as unequivocal as possible so that language (as in Carnap

and Morris) and terminology assumes tremendous importance. All obscurity of any sort is to be avoided at all costs.

Neurath, in accord with the basic idea of the unity of science, not only attempts to define science in very general terms, that is, in terms of a logical analysis of its statements and propositions, but also attempts to break down the conventional boundary lines among the sciences. The old distinctions between mental and physical, for example, lead to unsolvable problems and unfortunate predicaments. Thus there is the predicament of regarding geology as a physical science while it is forced to deal with sociological or historical data as well as with physical data. There is also the predicament of psychology considered as a mental science while it is forced to deal with physical and physiological data. Neurath therefore proposes:

Would it not be preferable to treat all the statements and all the sciences as coordinated and to abandon for good the traditional hierarchy; physical sciences, biological sciences, social sciences, and similar types of "scientific pyramidism"?  
(58, p. 8)

He suggests, further:

grouping statements where needed for orientation but not thinking of clear-cut departments. The various bodies of statements may overlap one another. Why should we object to that, since we do not object to the overlapping of scientific papers which may be titled "The Po Basin" and "The Alps." Let us regard the sciences

as collections of statements, just as we regard such papers. . . . (58, p. 9)

Similarly with regard to the social sciences, Neurath suggests that they be best regarded as, "a cluster of disciplines, each of which may be named for purposes of orientation but not for classification." (58, p. 8)

The similarity, or the points of agreement between F. H. Knight's position and the modern positivist position of Neurath may now be amplified somewhat. Despite the apparent rigidity of scientific empiricism, it is seen above that Neurath provides for inexactness, flexibility and adaptability as well as lack of certain predictability. He even goes further in stating that in place of true-false judgments of propositions and statements, there may be merely acceptance or rejection of them on a temporary basis. Also, Neurath advocates a pluralism, that is, a belief in the manysidedness and multi-naturedness of events, a belief which is similar to that expressed by Knight. It is also to be noted that Neurath does not propose (as might be expected he would on the basis of the apparent rigidity and radical nature of scientific empiricism) starting afresh with newly defined, simple, basic concepts. Rather, he believes that social science should start with its present indistinctnesses because they reflect a factual richness. In agreement also with Knight, Neurath rejects a simple cause-effect phraseology as inconsistent with holistic or aggregation theory. It



seems clear that a naive mechanism is rejected by both sides of the controversy.

### 8. The Views Of W. B. Donham Relative To The Distinction Between Natural And Social Science

Notwithstanding the points of agreement just noticed, the problem of the distinction between the natural and social sciences still seems to remain. Thus, W. B. Donham (59) (whose position in these matters seems identical essentially with that of F. H. Knight) recognizes the fact that naive mechanism patterned after Newtonian thinking has been greatly undermined and shaken by recent theoretical developments in physics and mathematics and that modern natural science has been altered accordingly. In this connection he quotes Irving Langmuir who points out that "the net results of the modern principles of physics has been to wipe out almost completely the dogma of causality." (59, p. 58) It is notwithstanding these radical developments in modern science, that Donham believes that science still remains mechanistic, deterministic, and materialistic thus rendering it inapplicable to social and human data and problems. Donham writes:

It seems obvious, however, that since the objective of science, within its most generalized objective of understanding nature, has been for many years the search for uniformities, and since the training of the scientists has been directed to this



end, most of them will continue this search, even when they leave the fields where overwhelming statistical probabilities determine results. Within the principle of uncertainty they will search for natural laws governing the behavior of minorities. The assumption of determinism will continue to work in great areas which deal with material things. The chemists' work is unlikely to stress uncertainties. The impact of science on civilization will still come to the man on the street in deterministic and mechanistic terms. The emphasis of science is materialistic in fact if not in intent. . . . (59, p. 59)

Donham (like F. H. Knight) thinks that scientific methods employed by natural science are not adequate or fitted for the study of human behavior. He writes:

The understanding of men and the uncertainties of social life require a wider integration and a different conceptual scheme. We can to advantage emulate (those of natural science) their spirit of inquiry, but not their methods (59, p. 65)

In the following he attacks the usual sort of positivistic social science which attempts to emulate entirely natural science methodology:

In the social science most specialities rest on an insecure logical foundation. They are isolated artificially from the sum-total of the social structure by omitting from consideration all but selected aspects of situations which are studied and by making explicit or implicit assumptions about the omitted factors. Social science specialists rarely grapple with human and social problems in their full concrete complexity. (59, p. 68)

According to Donham, then, for the social science specialities to be effective, they must deal with life in

all its complexity, uncertainty, variability, and as a totality. Social science has failed to be of any assistance in dealing with practical situations of life because it always tends to deal in abstractions, and with only parts or aspects of the whole practical situation. Practical knowledge, by itself, however, is always too narrow. Donham's final conclusion is that the "whole conceptual scheme of the social sciences and their objectives needs to be restudied and redefined in terms of life as men must face it." (59, p. 89)

On the question of discarding the conventional boundary lines among the various specialities of the social sciences, Donham seems in agreement with Neurath as well as with F. H. Knight. He argues against specialization in the social sciences on the grounds that life is a complex, variegated totality which therefore cannot be understood in terms of some special aspect considered apart from the whole. Donham concedes that specialization is inevitable but that it should always be counteracted by integration.

#### 9. Further Considerations Regarding The Distinction Between Natural And Social Science--The Position of S. Hook

Apart from philosophical considerations or beliefs with regard to the distinction between natural and social science such as have been discussed thus far, the plain

facts seem to indicate that there are differences actually existent between the two, at least, at the present time. One of the major differences may be seen in the fact as pointed out by Sidney Hook (60) that in natural science there is always substantial agreement as to meaning with respect to the statements or propositions advanced within a given particular science. There is always agreement as to meaning in the sense that in the natural sciences there is always intelligibility with respect to its statements and propositions even though there may be specific disagreements as to their truth or falsity. In the social sciences, on the other hand, there is wide disagreement and lack of intelligibility so that what is clearly understood and agreed upon in some quarters, may be, in other quarters, completely misunderstood, misinterpreted, and even regarded as constituting mere prejudice. To state the matter somewhat differently, the natural sciences constitute bodies of knowledge, or types of discourse, which command almost universal assent or dissent of all qualified, competent investigators or observers. The social sciences, on the other hand, do not command such universal assent or dissent since there exists, at the very start, a lack of agreement as to the meaning of propositions, and, consequently, no ways or means for arriving at assent or dissent.

Hook's own position relative to the distinction between the natural and social sciences is governed by

recognition of the facts just noticed. In agreement with the modern positivistic positions discussed above (Carnap, Morris, and Neurath), he thinks that the scientific method is applicable to social science problems. In the work here referred to, at least, Hook defends the thesis that one of the most frequent causes of intellectual confusion in the social sciences is the unintelligibility which arises out of the use of unanalyzed or unanalyzable abstractions. He defines a sentence containing unanalyzed or unanalyzable abstractions as one which cannot be tested out logically or empirically with respect to its truth or falsity. An unanalyzable abstraction has no specific reference and cannot, therefore, be understood. Hook states that the difference between the scientific empiricist school which is the one to which he adheres, and what he calls the intuitionist school involves the belief on the part of the former, that social science can be a science like physical science provided that, and insofar as, it advances verifiable statements and propositions which have spatio-temporal reference, or context. He writes:

The situation is briefly this: The empiricist aims to predict and control social events in the cultural world with the same set of methodological principles that he employs in the natural world. Recognizing all the differences that complexity in the subject matter and partisan bias make, he insists that the criteria of meaning and truth are one and the same whether we are discussing a man's weight on a scale (a physical

question), his metabolism (a biological question), or his political allegiance (a social question). The empiricist is perfectly prepared to admit that where he is investigating the social relationships between men, he cannot predict what will occur merely on the basis of his knowledge of the facts of physics or biology. He must know something more-- he must know the history, the traditions, the habits, and the language of the people whose behavior he is trying to predict. We can go still further and say that he must know, in many situations, their preferences, their emotions, their ideas. . . . (60, p. 25)

#### 10. The Outcome For Clinical Psychology

The major issue pointed up by the present discussion amounts to this: The position represented herein by F. H. Knight and W. B. Donham holds that a scientific methodology patterned after the natural sciences is inadequate for the social sciences. The main reason for holding this view is that the subject matter or type of data of the social sciences is unique and therefore demands a unique kind of methodology. This demand is not sufficiently met even by the non-naively mechanistic trend in modern science which attempts to take account of the unique quality of the subject matter of the social sciences.

The modern positivistic school, on the other hand, maintains that the social sciences must be formulated according to a scientific methodology patterned after

the natural sciences. Moreover, a natural science methodology must be followed notwithstanding the unique nature of the subject matter and all the conditions and implications which arise out of that fact.

The strength of the modern positivistic school arises out of whatever success is achieved with the crucial problem of presenting a very broad and general definition of what constitutes scientific methodology; a definition broad enough to cover the data of both natural and social science, yet limited and specific enough to remain thoroughly scientific. This is accomplished in terms of logic and/or language considered from the viewpoint of the requirements of intelligibility and effectiveness, rather than in terms of a slavish adherence to an outmoded conception of natural science. The strength of the anti-positivistic view seems to lie in the ability to point to certain realities of human beings and human behavior which have not been successfully dealt with by positivistic science. It should be recalled in this connection by way of demonstrating the strength of the anti-positivistic position, that at least one modern positivist, C. W. Morris, seems to admit the existence of the realities pointed to by the anti-positivists, and, indeed, goes further in so far as he demonstrates the validity of non-scientific modes of thinking and types of discourse in an effort to take account of and cope with



these realities. The earlier, and more usual positivistic approach tended to discredit and depreciate these non-scientific modes of thinking or types of discourse.

A certain amount of confusion relative to the distinction between the natural and social sciences may be cleared away. It is clear that social science may be defined in two main ways, a positivistic and a non-positivistic. If it is defined positivistically, social science virtually becomes natural science because of the pervasive character of the natural science methodology imposed on it. If it is defined non-positivistically, social science assumes quite a different character from natural science. Indeed, it becomes pertinent to ask whether it may still be called science, or whether it should better be considered as falling within some other realm of discourse outside the realm of science.

The outcome for clinical psychology of the discussion thus far may now be set down. This may be accomplished in the form of a list of tentative conclusions which may be distilled out of all the arguments presented.

1. Clinical psychology, at least at present, should not be considered a natural science in any traditional or complete sense. It is not, that is, a natural science in that it cannot be conceived in accordance with a rigidly mechanistic, materialistic, or



wholly deterministic methodology. Whether it be regarded as theoretically desirable or possible to attain a natural science methodology for clinical psychology, it seems nevertheless an inescapable fact that there are actual differences between a natural science and clinical psychology with respect to the amount of intelligibility and agreement possible to attain among qualified observers at the present time.

2. The most meaningful way in which to define science as far as clinical psychology is concerned, is in very general and broad terms--terms which are broader than those of any patterned after the natural sciences. The task of so defining science seems to be mainly in the hands of the scientific empiricists or modern positivists so that their efforts become particularly significant for clinical psychology. An important result of defining science in general terms is the tendency to break down or discard the conventional boundary lines among the sciences. Both the positivistic and non-positivistic schools seem to arrive at this result though on somewhat different grounds. The positivists discard the conventional boundary lines among the sciences from the standpoint of the unity of science movement, while the non-positivists destroy the conventional boundary lines among the sciences from the standpoint of their observations concerning the complexity and variability of human and social behavior.

3. From the standpoint of semiotics, the general and all-inclusive science of signs, it is important to define science specifically as C. W. Morris does, even though the value of defining science in general terms be granted. When science is so defined, clinical psychology seems to fall in non-scientific as well as scientific modes of thinking or types of discourse with respect to its various aspects. This gives clinical psychology a highly varied character since it cannot be considered wholly scientific or wholly unscientific.

4. Finally, it may well be agreed with the modern positivists that intelligibility, verifiability, confirmability, and even quantifiability are clearly and incontrovertibly assets in any mode of thinking. At the same time, it may be agreed with the non-positivists that the value of these assets is definitely reduced for the social sciences to the extent that the attainment of these assets entails overlooking the essential nature of human behavior regarded from the viewpoint of its complexity and variability. Moreover, it may be seen that the positivistic assets are limited to the extent that their attainment entails overlooking the problem of values as related to human behavior, a limitation which is extremely serious in view of the significance of values in human behavior.

## 11. Applied Science As Related To The Definition Of Clinical Psychology

Clinical psychology is often referred to, if not defined, as being an applied science. Some of the basic problems and issues involved in regarding clinical psychology as an applied science may now be discussed. First to be considered are the problems involved in making the distinction between pure and applied science.

One of the differences between pure and applied science may be clarified when regarded from the viewpoint of ethics.\* From the viewpoint of ethics, pure science seems to be based upon the ethical ideal of knowledge for the sake of knowledge as the highest or controlling virtue. This ideal stems from or is patterned after certain aspects of ancient Greek thought which placed supreme value on knowledge and regarded knowledge as the highest virtue. This is not to say that Aristotle, for example, left no room for the lesser practical virtues in his scheme of thinking, but simply to suggest that knowledge as such was regarded as the highest ideal and that the modern notion of pure science is largely controlled by that ideal.

Applied science seems to be based on two additional ideals, namely, the ideal of usefulness or utility and the

---

\* This discussion was suggested by a reading of F. H. Knight (57).

ideal of the brotherhood of Man. The grounds for the pursuit of knowledge are broadened by these more modern ideals. Knowledge is sought for the sake of its utility as well as for the sake of promoting the brotherhood of man, in addition to the ancient ideal of knowledge for the sake of knowledge. Moreover, in modern applied science, there is a significant interrelationship among all three of these ideals though the exact nature of which may not always be apparent with respect to a given applied science.

The problem of defining clinical psychology as an applied science may now be seen as one of ascertaining the role of these ideals in controlling the activities and functions of clinical psychology. If clinical psychology be regarded as being concerned with human behavior in all of its aspects particularly those involving human values; if clinical psychology is wholeheartedly and deeply concerned with Man, as Man, then the ideal of the brotherhood of Man or the ethics based upon the love of one's fellow man must be an important, controlling force. It may be added that if clinical psychology is concerned with Man in the fullest sense it would lose all meaning and significance were it not controlled by a consideration of human values. This, it is hoped, will become more evident in the chapter on ethics. The point at issue here is that clinical psychology may be

validly regarded as falling within the realm of applied science in the sense that its controlling ideal cannot be exclusively the ideal controlling pure science, and in the more specific sense that its controlling ideal must to a significant degree be the ideal of the brotherhood of Man.

The ideal of utility also plays a distinct role in clinical psychology. In connection with the history of this ideal in modern applied science, it may be noted that the realization of the methods of using abstract knowledge in technological pursuits was first accomplished, or attained in the nineteenth century chiefly in Germany, a fact pointed out by A. N. Whitehead (53, p. 142). The differences between technology and pure science have already been indicated during the discussion of C. W. Morris. Here, it need only be added that the ideal of utility is part of the technological mode of thinking, and that the meaning of applied science may be clarified in terms of technology as distinct from pure science. The sense in which clinical psychology as an applied science is governed by the ideal of utility also becomes clarified in these terms.

Most discussions of the distinction between pure and applied science usually enclose the terms pure and applied in quotes by way of indicating the uncertainty of the distinction. The present discussion has been concerned thus far with demonstrating some ways in which the distinction can be clarified and regarded as valid. Now, it

is fitting to point out some ways in which the distinction is uncertain or untenable.

The distinction between pure science and applied science is a dubious one, as John Dewey (51) indicates, when it is intended to imply that applied science is less exacting than pure science. The distinction is dubious also insofar as it is intended as a sharply, rigidly, or completely dichotomous distinction, for, as indicated in the previous discussion there is a close relationship between pure and applied science. This is clear, too, from the earlier discussion of technology according to G. W. Morris (52). It may be added that Morris points out another sense in which pure science is not completely pure. Science may be pursued for its own sake, but it follows from the very nature of knowledge that it proceeds from what is known to be true at a given time, and so is closely related to the problems, conditions, and state of knowledge existing at a given moment in history. Morris states:

It is certainly no accident that scientists at a given time are markedly concerned with getting knowledge relevant to the problems of that time; while science does not appraise or command a particular act, the knowledge that it seeks is significant knowledge, that is, information relevant to the accomplishment of various acts. No scientist has set himself the task of measuring the distances between the top of the Eiffel Tower and the corners of the headstones in all the cemeteries of Paris.

(52, p. 128)



He is probably thinking of scientific research in a very general sense and therefore does not mean that a specific piece of research always has an immediate demonstrable, everyday application and relevancy. Rather what he seems to be saying is simply that research cannot be carried on outside the existing framework of knowledge and outside the existing general needs and purposes of the times.

J. G. Crowther (61) goes much further than Morris in this matter when he presents the thesis that science is always related to the social and cultural environment in such a direct way that anything which occurs in science of the nature of discovery or research is directly dependent upon the social and cultural milieu. This leads Crowther to deny the existence of pure science because all science is intimately dependent upon culture and has a direct and immediate application to that culture. He admits a distinction between pure and applied science only on the basis of a difference in personal motives or consciousness of personal motives as experienced by the pure and the applied scientists, as seen in this quotation:

A scientist feels he is engaged in pure science when he is not conscious of motives other than his own volition and the internal logic of the development of the problem with which he is concerned. The latter is in his own mind, and appears to him to be independent of the environment and the external world.

A scientist feels he is engaged in applied science when he is strongly conscious of the external influences that have directed his choice of investigation. (61, p. 517)

Pure science for Crowther is merely an illusion that arises out of the scientist's habit of internal concentration on his research problems without his paying heed to, or being aware of, the social forces that are actually exerting a strong influence over the nature and direction of his research. Crowther further believes that the notion of pure science arises out of philosophical subjectivism which, for Crowther, is a wholly invalid position as he indicates here:

The view that science is an independent system of ideas is a product of subjectivism. It springs from the same motives as Plato's philosophy. . . . His (Plato's) representation of science as an organism of ideas independent of the material world appears to be disinterested, but in fact it concealed political ambition. . . . (61, p. )

Crowther seems to be entirely correct in pointing out that the scientist should be concerned with the social aspects and effects of his research, that he should recognize the ethical implications involved in contributing knowledge to society. He seems to go too far, however, in denying the existence of pure science, as such. What Crowther calls external influences most probably do affect the direction and the speed of scientific research, but they do so only in a general way. He seems also to overlook the

fact that the relationship probably works in both directions, that is, that pure scientific research influences the social milieu as well as being influenced by it. There is not a one-way direct relationship between social needs, social forces and scientific knowledge, as Growther evidently holds, but a complicated interrelationship on a general rather than a specific level.

Further, Growther seems to confuse the issue by introducing a consideration of personal motives. The non-personal motive, intent, or purpose as reflected in an ethical ideal seems to be a valid consideration, as noted earlier, but the personal motive, in the psychological sense used by Growther, does not seem to have a direct bearing on the matter. Men may have a wide variety of different motives on a personal or psychological level with respect to carrying on identical or similar activities. Also men may carry out vastly different activities and yet have similar personal or psychological motives. It becomes difficult, therefore, to say anything about the nature or character of an activity, such as a scientific pursuit, simply on the basis of the personal motivation of the participants in that activity.

## 12. The Problem Of Rapprochement Of Pure And Applied Science

Some problems involving the distinction between

pure and applied science have been discussed by way of throwing some light on what it means to refer to clinical psychology as an applied science. It is now necessary to stress that no matter what decisions are made with regard to the validity of the distinction between pure and applied science in general, it is highly questionable to regard clinical psychology as falling exclusively in either the realm of pure or applied science. That the distinction cannot be a wholly complete or sharply defined one, and that there is a necessary interrelationship between pure and applied science has already been indicated. What needs to be amplified now is that the problem of the relationship between pure and applied science is of special and basic significance for psychology and clinical psychology. The special significance arises from the fact that clinical psychology represents an attempt to deal with human nature and behavior in all their highly varied aspects and multiple complexities. In order that such attempt be at all successful, both from the viewpoint of the theoretical as well as of the practical issues involved, it becomes necessary to effect an integration of the pure and applied forms of science.

Gardner Murphy (62) illustrates this point in reference to intelligence as a problem in psychology which cannot be studied adequately or treated in terms of either pure science or applied science on an exclusive basis.

He points to the vast gulf that exists between the academic-laboratory research which deals largely with abstract aspects of the problem of intelligence and the tremendous exigency of the problem of understanding the dynamic aspects of thinking, i.e., the feeling, impulsive, and motivational aspects of thinking. By way of demonstrating this gulf between academic, pure research, and the applied problems of intelligence, Murphy traces the different traditional paths followed by pure and applied psychology. He shows how "solidly intellectualistic" most all of the academic-laboratory research has been in that the abstract elements of intelligence are divorced from and treated separately from the dynamic and emotional aspects of intelligence and thinking. Even for Gestalt psychology which challenged associationism, Murphy states, "there was scant recognition that mind is an evolutionary product in which the impulsive life gives quality and direction to the cognitive effort." (62, p. 3)

Applied psychology, on the other hand, has always had to deal with the practical aspects of intelligence which are precisely those dynamic aspects neglected by or inadequately treated by academic-laboratory study. As Murphy writes:

Applied psychology has. . . been confronted throughout its existence with just those forms of thinking in business and industry, in clinic and in court, in school

and in public opinion, which arise from a matrix of needs, and consequently provide major clues to the effective organization of the thought processes. Clinical psychology is intimately concerned with the distortion of the patient's world-view by affective factors in open or covert conflict with one another; while in the evaluation of the patient's intellectual resources the clinician observes the limits imposed upon the patient's intelligence by his need to see, to learn and to think in accordance with his drives, exhibiting a functional level of intelligence far removed from the measured capacity revealed by any test. Similarly, studies of industrial conflict have shown that injured egos and blind stubbornness can daily break the fine thread of understanding which practical self-interest and human reasonableness have tenuously spun between management's and labor's viewpoints. (62, p. 3)

Murphy's major point, in the paper cited, seems to be that adequate study of human behavior as a whole demands the integration of both pure and applied scientific methodologies because the vital, the dynamic and the significant problems encountered in the applied fields where human behavior is observed constitute the data necessary for a complete study of human behavior, while the most efficient methods for such study often come from the laboratories.

The only type of fractionation Murphy is willing to grant as necessary in psychology is an administrative fractionation of tasks. He writes:

Only that type of unification of pure and applied psychology which would fractionate



the administrative tasks to be performed, but not the organic unity of the human being, would serve to the advancement of psychology. That type of fractionation which would cleave and sunder the human being into pure and applied functions, or pure and applied areas of activity, could easily prove retrogressive. If the clinical or business psychologist or the public opinion investigator can discover problems of broad and profound significance, these must be presented where people with laboratory facilities can see and understand them; and if the laboratory psychologist discovers new principles which he believes should have social usefulness, he needs an audience sympathetically attuned to such a presentation. (62, p. 18)

J. G. Miller (63) devotes a good deal of space in a recent book to the problem of the rapprochement of pure and applied psychology with special reference to the problem of clinical versus laboratory psychology. In much the same way that Murphy regards the problem of intelligence as illustrative of the need for rapprochement of pure and applied science in psychology, Miller sees the problem of unconsciousness as illustrative of the sort of problem which demands the active co-ordination of the clinical or applied approach and the laboratory or pure scientific approach. He gives many different reasons why the problem of co-ordination between clinic and laboratory is an extremely difficult one. There is the historical fact that clinical psychology developed as an outgrowth of medicine and thus became oriented toward psychopathology and toward practical problems of diagnosis and treatment. The laboratory or experimental psychologists, on the other hand, were

oriented toward an understanding of the normal or typical and had little concern with practical problems. Miller also points to the historical fact that academic departments of psychology both in this country and in Germany were organized and set up independently of medical faculties with the result that there existed a state of isolation between the academic and medical faculties.

As a second reason for the lack of co-ordination between the clinic and the laboratory Miller points to the disparity of their purposes. Here he refers to the clinician's interest and concern in the individual in contrast with the experimentalist's concern with the many and with general laws. Miller alludes briefly to the controversy about the scientific validity of the individual approach, a question treated in another portion of the present study at greater length.

Closely related to the disparity in purpose, is the disparity in procedure. The experimentalist has always given a great deal of attention to establishing experimentally controlled studies based upon a large number of cases. Further, the experimentalist often uses the method of analysis in an attempt to understand in terms of a breakdown into elements or factors. The clinician, on the contrary, has little opportunity for making controlled studies and has to rely on more or less natural, unmanipulated situations for making his observations. In addition, the

clinician takes the individual as a whole as his unit and very seldom resorts to an analysis in terms of smaller elements or units.

Miller also finds a difference in temperament or personality between the clinician and the experimentalist, about which he states:

Clinical psychologists tend to be in general intraceptive, and academic psychologists on the whole are extraceptive. (67, p. 7)

The terms intraceptive and extraceptive are those used and defined by H. A. Murray, the former signifying an imaginative, subjective, human outlook; the latter signifying a practical, down-to-earth skeptical attitude.

Miller's own attitude toward the entire problem of the relationship between clinic and laboratory is that it is well to understand and appreciate these temperamental differences and those which arise out of the diverse historical backgrounds, purposes, and procedures, but that the problem of co-ordination is not insoluble. He reviews some of the evidence and signs of rapprochement and concludes:

The rapprochement of the laboratory and the clinic is not yet a large, a self-conscious, or a vocal movement, but it has begun. (63, p. 13)

It is significant that Miller points to medicine as a field in which there is good co-ordination between clinic and laboratory which might well serve as a pattern for psychology.

### Chapter III

## SOME BASIC PROBLEMS REGARDING ART AS RELATED TO THE DEFINITION OF CLINICAL PSYCHOLOGY

### 1. General Plan of Chapter

At several points in the preceding chapter, it was implied that clinical psychology may not be defined entirely in terms of science--natural, social or applied--but that it may also be necessary to refer to the concept of art in order to gain a full understanding and appreciation of clinical psychology as a generic discipline. The notion of applied science requires reference to certain aspects of the concept of art so that what has been said on that topic should have a bearing upon the present discussion. It is believed, however, that more specific reference to the concept of art is necessary. Just as in the case of science, there are many controversial problems and issues involved in any attempt to define clinical psychology as an art, or in any attempt to exclude art from the definition. An effort is made here to single out some of the more vital issues, and to present several sides of the controversy pertaining to them.

As a good deal of the material presented here is vital to any attempt to understand the specifically clinical aspects of clinical psychology, it may be helpful to

conceive of this chapter as devoted to the problem of the meaning of the term clinical. However, it is believed that the concept of art provides a useful general frame of reference in terms of which the concept, clinical, may be more clearly understood. Much of the controversy about the meaning of the clinical concept always seems to involve either implicit or explicit reference to art, usually the former, since the concept of art in relation to clinical psychology has received little formal consideration.

This discussion, then, is oriented to the concept of art in relation to clinical psychology, and is largely concerned with presenting the debate that has centered around that concept. Clarification of the meaning of the clinical concept should also come out of the discussion, however, and it is planned to focus the last section of the chapter on a more specific consideration of the term clinical.

## 2. The Issue of the Single Case

One of the important meanings of the concept of art as it is employed in defining the nature of clinical psychology, is that meaning which arises out of the fact that clinical psychology is greatly concerned with the single case. Clinical psychology is deeply concerned with the individual as an individual and on a highly personal

plane so that its methods have often been described as artistic. This fact makes it imperative to understand the methodology of the single case, and to understand whether the single case method can be accepted as scientific, or whether it must be accepted as a form of art. If it is believed that a concern with the single case necessarily involves an artistic methodology rather than a scientific one, then clinical psychology must be regarded as an art. If it is believed that a concern with the single case does not necessarily mean discarding the methods of science, then the single case method must be shown to be scientific or capable of being handled according to the methods of science, which in most instances demands a redefinition of science.

Gordon W. Allport (64) has been greatly occupied with the issue of the single case especially as related to the use of personal documents in psychology, and takes the position that the single case can be treated according to the methods of science. As Allport is one of few psychologists to undertake an analysis of the methodology of the single case, it is pertinent to review his contributions in some detail.

Personal documents as defined by Allport constitute a large part of the data of clinical psychology. The personal document is defined as;



Any self-revealing record that intentionally or unintentionally yields information regarding the structure, dynamics, and functioning of the author's mental life. It may record the participant's view of experiences in which he has been involved; it may devote itself deliberately to self-scrutiny and self-description; or it may be only incidentally and unwittingly self-revealing.

(64, p. xii)

As so defined personal documents comprise only first-person documents with which Allport is primarily concerned in the monograph to which reference is being made. Third-person documents, however, are also defined by Allport and are methodologically similar to first-person documents in that they both involve the single case method. They are defined as personal documents which are written by

an "outside" investigator to depict the essential structure and functioning of some other personality by recording as many of the environmental and intrapsychic conditions as are necessary to yield an understanding of the personality in question.

(64, p. xii)

Third-person personal documents are more widely used than the first-person documents in clinical psychology and are usually referred to as case-histories, case-records, or case-studies. First-person and third-person documents may, for the purposes of clinical psychology, be referred to as "human documents," a term also used by Allport.

Allport reviews the history of personal documents or human documents and finds that their early use

was characterized by enthusiasm and vitality but also by a lack of methodological sophistication. The documents, in brief, were used uncritically. In respect to clinical psychology particularly, Allport cites the work done under Lightner Witmer as published in the journal, The Psychological Clinic. Allport writes:

The editorial policy of no other psychological periodical has ever invited the scientific use and exploitation of the personal document to such an extent as did the Clinic. In the 28 years of its existence well over 200 individual cases were printed along with many articles of general interest on the subject of mental deviation. Yet, for our present purposes, the history of this journal has a merely negative outcome. Not one single critical article on the method of the case study was published, and nothing beyond the most incidental and pedestrian use of personal documents is to be found in its files.

(64, p. 16)

Allport suggests in connection with the above statement that the time is ripe for scientific and critical study of clinical cases.

As another historical example of the uncritical use of personal documents in clinical psychology Allport discusses the work of Freud. He points out that Freud regarded the single case merely as an illustration or exemplification of a general principle or theory rather

than as a valid datum in itself.\* Allport believes that this attitude toward the single case is characteristic of many clinicians in addition to Freud and his students insofar as they tend to regard the single case as typical of the many rather than as individually significant and valid in itself.

Further he reviews a good deal of the work that has been done since the advent of what he calls the "critical age" in the use of human documents. Thus, he evaluates the work of J. Dollard (a\*) and comes to the conclusion that:

Dollard sets up his standards for the use of documents in accordance with his personal predilections for culturism and Freudianism. Such a private system of judgement should be replaced, if possible, with rules for the interpretation of documents based on external sanctions.

---

\* Allport, however, also shows that there is a wide discrepancy between the actual clinical practice and the writings of Freudians on this point. In practice they pay a great deal of heed to the delicate and subtle individuality of the patient while in their writings they are intent upon proving a theory and seem to press the individual case into the economy of a theoretical mold. Freud is also praised by Allport for his "high regard for professional ethics in the use of personal documents. He (Freud) repeatedly warns his followers against breaches of professional secrecy. The anonymity of a case, he insists, should be scrupulously preserved." (64, p. 11)

a\* Dollard, J. Criteria For The Life History--with an analysis of six notable documents. New Haven: Yale University Press, 1935.

The Life History In Community Studies, Amer. Sociol. Rev., 1938, pp. 724-737.

The happy fact that such rules are now being sought may be credited largely to Dollard's courage in boldly asserting his own preferences, and in calling attention to the possibility of establishing standards for the preparation and evaluation of case material in social science. Single-handed he has blazed a trail into the forest, and many will follow to work there until the forest is cleared. (64, p. 30)

The work of Frenkel-Brunswik (b\*) is cited by Allport as a tentative step toward solving the problem of self-deception as related to personal documents. Frenkel-Brunswick's experiment shows, for him, the possibility of establishing objective standards or symptoms for discovering or judging the presence of self-deception in personal documents. The work of Cartwright and French (c\*) on the problem of the reliability of life histories is also cited by Allport as another study carried out in the critical age of the study of human documents. The important findings in this study are (1) that predictions of independent investigators relative to a particular personality may be both valid yet unreliable in the sense that the predictions cover different aspects of the personality, and (2) that agreement on concrete levels of behavior is more easily obtained than on conceptual levels of behavior.

---

b\* Frenkel-Brunswik, E. "Mechanisms Of Self Deception," J. Soc. Psychol., 1939, pp. 409-420.

c\* Cartwright, D., and French, J.R.P., Jr. "The Reliability of Life-History Studies," Char. & Pers., 1939, pp. 110-119.

That is, agreement as to what is happening in a personality is more easily obtained than as to why it is happening.

Allport regards Polansky's study on how a life history shall be taken as another significant example of a "critical age" experiment in human documents.\* The general findings of the Polansky study are that of six modes of predicting personality defined as (1) the structural (emphasis on contemporary traits, attitudes and ambitions), (2) the cultural (emphasis on community and family factors), (3) the genetic (emphasis on longitudinal patterns and early events), (4) the major maladjustment mode (emphasis on psychiatric factors), (5) the episodic mode (emphasis on anecdotal behavior events), (6) the individual difference mode (emphasis on test scores and psychometric results)-- of these six modes, the structural mode is the most efficient. Polansky also found that the efficiency of a particular mode of prediction is the most important factor involved in making correct predictions concerning personality, while the predictability of the subject, and the capacity for judging on the part of the judge follow respectively in importance.

Allport finds the following points of significance about Polansky's work: (1) its practical merit of

---

\* Polansky, N.A. "How Shall A Life History Be Written," Char. & Pers., 1941, pp. 188-207.

instruction on how to write case studies which offer predictive power, (2) its theoretical importance for personality theory (validating structural versus a statistical-psychometric theory), (3) its indication of the likelihood that one personality may best be conceptualized, described and interpreted in one mode as based upon one theory of personality, while another personality may best be interpreted in another mode according to another theory. As Allport eloquently puts it:

It seems improbable that an infinite variety of mortals--with lives structured according to contrasting themes, with greater or less conformity to cultural norms, with or without a neurotic vortex, infantile or adult in type--can or should be expected to represent themselves equally well through any one prescribed form of life-writing. (64, p. 35)

As a final example of critical age study of human documents, Allport cites the work of A. L. Baldwin who applied statistical methods to an analysis of a single case in that he statistically analyzed the contents of a collection of letters written by an individual. Allport's evaluation of Baldwin's work is of special importance as a datum in clinical psychology:

The method (Baldwin's) is of considerable importance representing, as it does, a contribution to the exact analysis of the structure of the unique single personality on the basis of personal documents. It sets forth a new conception of a "population" for statistics: a population of events and traits within the boundaries of one person. If the initial promise of



this method is fulfilled it will supply an important bridge between the statistical and clinical points of view. (64, p. 36)

### 3. The Issue of the Single Case as Related to the Nomothetic-Idiographic Issue

Allport relates the problem of understanding personal or human documents and the issue of the single case to the larger issue of the validity of the nomothetic as distinct from the idiographic forms of knowledge--terms adopted from W. Windelband, the German philosopher. Allport regards this issue as central to the task of evaluating human documents. The issue is also central for clinical psychology since human documents constitute a large portion of the data of clinical psychology.

Human documents as raw data may lend themselves to either nomothetic or idiographic treatment, Allport points out. From a nomothetic point of view, documents may be collected in great numbers and statistical methods may be used to discover common factors and thus arrive at general laws; while from an idiographic viewpoint, a single document may be fully and validly described in all its uniqueness with respect only to understanding and control of the single case. Allport believes that both forms of knowledge are valid, an important point to note, since his defense of idiographic knowledge may easily be interpreted to mean a complete denial of nomothetic

knowledge. His position is clear from the following statement:

Either the nomothetic or the idiographic framework of evaluation taken alone is too narrow, for the personal document is capable of supplying what the mind craves in both its nomothetic and idiographic moments. (64, p. 54)

Allport frames his arguments against the prevailing scientific sentiment and bias in favor of the exclusively nomothetic approach. In psychology, the nomothetic approach consists of a search for abstract generalizations at the expense of concern for the particular concrete aspects of human life. Nomothetic psychology omits or overlooks the possibility of the uniqueness and individuality of a human personality. It assumes that causation is necessarily identical from case to case and that lawfulness is dependent upon frequency of occurrence. On the other hand, idiographic psychology recognizes that causation may be personal and particular to the individual.

The pervasive and far-reaching import for clinical psychology of the nomothetic-idiographic issue can be seen from the following statement made by Allport:

If nomothetic procedures were sufficient we should expect that the psychometric profile or standardized schema of inquiry would replace the cumbersome case document. Psychometrics is the nomothetic discipline that determines the degree to which individuals deviate from an average in respect to variables chosen by the scientist. Experience, however, has taught us that psychometrics

is an inadequate instrument in clinical psychology. With all its weaknesses the case study remains the preferred tool of all clinicians, psychiatrists, personnel officers, and consulting psychologists. They find that the single case cannot be reduced to a colligation of scores. Here, then, we encounter a pragmatic reason why idiographic procedures must be admitted to psychological science; practitioners demand them. (64, p. 58)

Although the argument from practice in the above statement seems valid, Allport is perhaps taking too much for granted about the acceptance of the idiographic approach on the part of all clinicians. He seems to presume that the battle for idiographic knowledge is won, but what he probably means is simply that many clinicians have found the exclusively nomothetic approach unsatisfactory and that the clinical case by its very nature demands the idiographic approach. Allport is, of course, arguing from the standpoint of general psychology, but as far as the present thesis is concerned the issue is still a live one even for clinical psychology. At least, its formulation has never been clear for clinical psychology in any self-conscious way.

In presenting the theoretical argument in favor of idiographic knowledge that the application of knowledge must always be to the single case, Allport comes upon a valuable insight into the essential nature of the clinical approach. The general law or generalized knowledge, he argues, is never directly applicable to a particular

personality without first being particularized and modified by the concrete circumstances surrounding the particular personality. Nomothetic knowledge must be altered and sometimes even negated by idiographic knowledge about the personality. This means that while there may be and most probably are general laws of human behavior, they are only approximately true or incompletely applicable where a particular individual case is concerned because each case may to a degree follow its own unique laws.

The several issues raised so far may now be briefly summarized as they pertain to clinical psychology. The issue of whether clinical psychology is an art or a science depends in part at least, on the issue of the single case, and its status as a valid datum for science. The issue of the single case, however, is part of the larger issue of the validity of idiographic knowledge as science. It is seen, furthermore, that the essence of the clinical approach, which is to say the essence of the practice of clinical psychology as distinct from general psychology, lies in the fact that it uses idiographic knowledge. Even though it be granted that idiographic knowledge has no place in psychology as a science interested in discovering general laws of behavior, it does not follow that idiographic knowledge plays no role in clinical psychology. The question of whether clinical psychology is to some extent an art depends upon whether idiographic knowledge can be accepted as

science or whether it must be regarded as art. This later question as to whether idiographic knowledge is part of science in turn depends on what is accepted as the definition of science. The problem of defining science was dealt with in the last chapter where at least one thing was clearly shown, namely, that the concept of science has undergone radical change in the past and will probably continue to change. The concept of science is not absolutely fixed, at least there seems to be room for a variety of approaches toward its definition and Allport's approach seems to merit a hearing. Before proceeding to this, it must be re-emphasized that whether idiographic knowledge be regarded as falling within the realm of art or science, there seems no denying the fact that it is the form of knowledge used extensively, though not exclusively, by clinical psychology. This fact provides an insight into the essence of the clinical approach and of clinical psychology.

Allport attempts to include idiographic knowledge as part of science and in doing so must define science in an anti-positivistic way--in somewhat the manner followed by F. H. Knight and W. B. Donham as indicated in Chapter II. Science, for Allport, is defined in terms of its aims, "to give man an understanding, a power of prediction and a power of control, beyond that which he can achieve through his own unaided common

sense" (64, p. 148). He holds this view of science because he believes that the purposes of science are just as important as its language, which is in contrast, Allport thinks, to the strictly positivistic view that language is all important in defining science.\* He believes that since human documents which depend on idiographic knowledge can yield understanding, control, and prediction (and his whole monograph constitutes an attempt to demonstrate that they can), they must be admitted as valid data for science.

It is interesting to note that in order to include idiographic knowledge within science, Allport not only finds it necessary to define science in a broad way in terms of the three aims of understanding, prediction and control, but also finds it necessary to point out that these three aims may be partially independent of each other. Understanding may be attained even though it may not be possible to make predictions with respect to some phenomena, and control may be possible without either understanding or predictability. Allport's illustrations of these circumstances reveal the peculiarly uneven development of the social sciences. He writes:

We can, for example, predict that a paranoid patient will behave true to his

---

\* It is important to recall, here, that at least one modern positivist, C. W. Morris, does not omit a consideration of purposes in defining science or any other realm of discourse. See Chapter II on C. W. Morris.



delusion without being able to understand the causes of his condition or to prevent its continuance. We can understand at least some of the causes of war, but cannot at present either predict its course or prevent its coming. Finally, we can control a population through force without in the least degree understanding its mentality or predicting its behavior if the control is slackened. . . . (64, p. 149)

Allport also insists that the aims of science may be carried out on either or both the nomothetic and idiographic levels which amounts to saying that there are six rather than three aims of science. He stresses the idiographic aims in his monograph because they are usually neglected.

In relation to "understanding" as an aim of science, Allport attempts to show the importance and significance of the individual, the concrete and the particular in the attainment of knowledge and concludes that:

no understanding of general laws is possible without some degree of acquaintance with particulars. If we may assume that the concrete and the general are of equal importance in the production of psychological understanding, it follows that case materials (including personal documents) should claim half of the psychologists' time and attention. (64, p. 151)

This means that insight is a process of interaction between general (inferential, nomothetic) knowledge and particular (intuitive, idiographic) knowledge. The important points that Allport makes in connection with his

concept of insight and in respect to including idiographic knowledge as part of science rather than of art is that insights can be subjected to a process of confirmation of their validity. This process of confirmation or checking of insights involves such things as obtaining the endorsement of independent investigators, evaluating the internal consistency, i.e., is an insight or interpretation consistent with the character of the case as a whole, and evaluating the predictive success of an insight or interpretation. The case conference, Allport points out, amounts to another method of checking the insights of a particular investigator against the insights of other investigators on the same case. This indeed constitutes the greatest value of the case conference since in the face of the diversity and complexity of human case material, no one investigator may be expected to deal successfully with the case as a whole.

#### 4. The Issue of the Single Case in Relation To the Problem of Prediction

Prediction seems to be most widely accepted by modern scientists as being the central if not the sole concern of science. The majority of scientists, however, tend to regard prediction in the single case as outside the realm of science. This, Allport argues, is an unfortunate tendency because prediction with regard to the individual

case must be included as within the science of psychology if psychology is to be a science of any value. He writes:

If psychology cannot help in forecasting, guiding, or in restraining the conduct of individuals in accordance with the requirements of social well-being, it is a science of little value.

(64, p. 156)

The usually accepted approach to the problem of prediction in the single case is an approach from a statistical or actuarial standpoint. Predictions in the single case are made on the basis of how the new single case compares with what has happened in a great many cases which have been statistically analyzed with respect to a certain number of variables. This practice is prevalent in areas dealing with the prediction of adjustment in marriage, parole, etc. Allport agrees that this sort of prediction is valuable where a great many cases or a large population of cases are concerned but may not be dependable for a particular single case. He argues:

A fatal non-sequitor occurs in the reasoning that if 80% of the delinquents who come from broken homes are recidivists, then this delinquent from a broken home has an 80% chance of becoming a recidivist. The truth of the matter seems to be that this delinquent has either 100% certainty of becoming a repeater or 100% certainty of going straight. If all the causes in his case were known, we could predict for him perfectly (barring environmental accident). His chances are determined by the pattern of his life and not by the frequencies found in the population at large. Indeed, psychological causation is always personal and never actuarial.

The only way to make a certain prediction of effect from cause is to study the life in which the causes operate, and not a thousand other lives. This is not to deny that actuarial prediction has its place (in dealing with masses of cases); it is good as far as it goes, but idiographic prediction goes further.

(64, p. 56)

Another error made by the actuarial approach to prediction in the single case is pointed out by Allport as consisting of the false assumption that the "same apparent circumstances have the same meaning (and therefore the same value) for all individuals." (64, p. 157) Thus, for example, marriage is taken to mean the same thing to all individuals when it is used as a factor or variable in the prediction of parole success. This overlooks the patent fact that the significance of marriage varies tremendously from person to person. Knowledge of what marriage means to the particular individual must form the principal basis for making a prediction regarding its role in parole success.

Allport attacks the whole view that scientific prediction can only be based upon a logic of recurrence, and upon a theory of causation based upon the frequency of connections. This philosophy Allport regards as naive empiricism and remarks that it provides, "the intellectual climate of American social science" without which "the commanding influence of the statistical outlook could not have developed." (64, p. 158)

In attacking this view, he attempts to show that individual behavior may occur in entirely new and emergent patterns and therefore cannot be predicted in terms of past behavior. A murderer may not have committed a murder before, yet, scientifically speaking, his behavior is determined. The same thing may be said about other forms of behavior such as marriage. Allport sums up the argument with this statement:

If predictions based on frequency were all that were possible, then a Hollerith machine worked on the basis of known frequencies by a robot could predict future behavior as well as a sensitive judge. What is missing from the code-and-frequency device is the perceiving of relations, the reasoning as from present indications to changes (not repetitions) that will occur in the course of time, and the variation of prediction by recognition of contingent factors (allowing, for example, for probable changes in the environment). (64, p. 159)

The position of T. R. Sarbin is more representative of the views held among the majority of scientists. Sarbin (65) notes that there is a great deal of literature on the problem of the actuarial versus the individual approach to prediction and that on the surface there appears to be a valid distinction between the two approaches. He argues, however, that the notion of probability is always involved in prediction of behavior so that all prediction must be based on statistical analysis. The concept of frequency he points out is basic to the notion of probability as used

in ordinary statistical prediction. In individual prediction or in what amounts to clinical prediction, however, Sarbin notes that it is maintained that frequency is unimportant, which if true, means that the clinical and the statistical are actually distinct and disparate methods or approaches. Sarbin attempts to show that in the clinical approach based on the single case that analysis is either implicitly carried out on the basis of frequency, or else it is completely non-scientific and therefore invalid--similar to predictions made by primitive, pre-scientific man in the era of magic.

Sarbin's position, thus, necessarily involves the complete denial of the existence of the single case as a valid datum. For, every case must be ordered to a class of events if it is to be at all capable of being understood. It is of utmost importance to note, however, that Sarbin defines his concept of class to include events that may happen within or peculiarly to the individual as well as events that may happen in a group the latter being the usually accepted concept of class. Although Sarbin introduces this novel concept of class only incidentally and merely by way of offering further clarification of his argument against the single case school of thought, the definition actually weakens his whole position. For, by including events peculiar to an individual as constituting proper data for the application of the probability principle,



Sarbin virtually accepts all the claims and demands of those who like Allport argue for the validity of individual or clinical prediction in the single case. All that Allport demands in essence is reference to the individual as shown by his citation of and remarks about Baldwin's study wherein statistical analysis is used in connection with a single case.\* Allport would not deny the validity of the principle of probability as such or as it applies within the framework of an individual case. Indeed, he points out that studies like Baldwin's can provide the basis for a reconciliation between the statistical and the clinical approaches. Sarbin's broadened concept of class might serve in the same way provided he would be willing to admit that the group and individual situations are different even though the probability principle may be seen to operate in both situations.

The outcome of the arguments presented by Allport and Sarbin seems to be that there is no denying the probability principle, nor is there need to deny the validity of individual dynamics, or uniquely determined individual events. The probability principle may be seen to operate in both the group and individual situations, as Sarbin himself points out. This does not mean that predictions based upon the probability study of a group are directly

---

\* See p. 117.

applicable to the problem of prediction in the individual case. Therein seems to lie the confusion in Sarbin's position.

These last comments seem to be substantiated by a recent monograph prepared by Horst, Wallin and Guttman (66) which surveys the logical problems involved in the prediction of personal adjustment, and makes it very evident that the logical considerations are not as simple as Sarbin (65) would seem to indicate. According to Horst (66), the prediction problem involves detailed consideration of two sets of constantly interacting factors, namely the personal and the situational. The personal factors are usually described in terms of traits or personality characteristics while the situational factors are the external and relatively independent factors in the total environment of the person. The situational factors are in turn classified by Horst into two categories, namely the manipulable and the relatively non-manipulable factors. The former factors are those which may be altered and changed, while the latter non-manipulable factors refer to the relatively changeless, more stable, and uncontrollable factors such as, for example, weather and many cultural factors. The significant point of this approach is that it provides Horst with a basis for evaluating the case study method in a positive way in relation to the statistical method. Briefly, the

case study method makes its greatest contribution in providing an intensive analysis of the manipulable situations and the person's relations to these situations. It takes account of what Allport terms the idiographic or dynamic factors, while the statistical method best deals with the non-manipulable, the stable, the nomothetic factors.

Throughout the study cited above the authors maintain the position that the actuarial prediction method and the case study or clinical method are best regarded as complimentary rather than mutually exclusive ways of predicting behavior. At one place, the "crucial and inescapable points" on which both sides of the controversy should agree are listed as follows:

- (1) that the case study procedures are often a powerful method of gaining a better understanding of an individual;
- (2) that they are indispensable to direct prediction in the absence of known functional relationships between specified information and associated behavior which will permit a high percentage of correct judgments;
- (3) that they are invaluable to the process of hypothesis formation, not only in giving initial hunches\* about interrelationships of factors, but also in interpreting the exceptional cases, after a given stage in an analysis is completed, thus leading to a new hypothesis and an improved analysis.

(66, p. 29)

The problem of evaluating the actuarial and the case study or clinical method is directly related to the

---

\* Which is as far as Sarbin (65) is willing to go in his evaluation of the case study or clinical method.

problem of linearity of relationships among variables that may be involved in prediction in that variables may be related in either a linear or non-linear way. Horst points out that most work in the field of statistical prediction of personal adjustment proceeds on the assumption of linear relationships. (This is the assumption which seems to be implicit in Sarbin's (65) work.) Horst further points out that this assumption may often prove to be false. He writes:

Investigators who have worked extensively with case materials have been impressed by the fact that it is impossible in many cases to take a general weighted average of all the factors involved and use this average as a basis of prediction of marital adjustment, vocational success, school achievement, behavior on parole, etc. In individual cases certain factors are much more important than others in the extent of their influence, and it is the configuration of factors which seems to be significant. It is emphasized that for certain individuals one, or at the most several factors, are so powerful that they will be almost the sole determiners of success or failure in the particular activity under consideration.

Much the same ideas have been emphasized by the Gestalt psychologists and other investigators with the configurational point of view. These investigators point out that the end result depends on the interrelationships of the various parts. (66, p. 81)

Horst states that little work actually has been done on the problem of non-linear relationships among variables in a prediction system but he apparently thinks

that methods can be developed to handle the problem successfully. The inference may be drawn that if such methods are developed then the case study method can be discarded, but pending the development of such methods for the successful mathematical analysis of dynamical systems in which there exists non-linear relationships among variables, the case study method is indispensable.

The issue of the single case as it pertains to clinical psychology may now be viewed in the light of some statements by Quinn McNemar (67). In the following quotation he argues against the single case:

Surely, psychologists have learned that very little light is thrown on, say, criminal behavior by a minute clinical study of one case, yet we are expected by some to believe that the mysteries of human personality will somehow be unraveled by an intensive study of just one case. Perhaps knowing all about one case may be important, even though of highly limited significance for the next and next case. (67, p. 362)

McNemar's observations may be true for general psychology or even for clinical psychology in so far as it is interested in discovering general laws of human behavior, and McNemar probably made his observations from that standpoint. Nevertheless, it must be insisted that clinical psychology as a practice must deal with the individual as an individual, and therefore must deal with the single case whether the single case method be regarded as scientific or artistic. McNemar's statement that the

single case "may be important" must therefore be altered as far as the practice of clinical psychology is concerned, to the statement that the single case is extremely important if not all-important.

Further, it should be noted that even McNemar who is regarded as an outstanding statistician and might therefore be expected to represent a radically statistical point of view, does not discard the single case method entirely, even for general psychology. He writes:

The statistician who fails to see that important generalizations from research on a single case can ever be acceptable is on a par with the experimentalist who fails to appreciate the fact that some problems can never be solved without resort to numbers. The single-case method and the statistical method are, of course, somewhat opposed, but each has its merits and each its shortcomings. Many examples could be enumerated in which a single case provides sufficient data for checking hypotheses and drawing generalizations.

(67, p. 361)

McNemar's view is that the single case is valid in research when dealing with behavior characteristics which are relatively non-variable and present no sampling problem. The non-variability of course must be demonstrated, or whatever variability may be present must be shown to be unimportant. He does not, however, believe that this single case ideal is attainable because experimental controls are always far from adequate in psychology. If psychology were a general science in the strict sense of being capable



of discovering laws or generalizations which were true for each individual in particular as well as for all individuals in general then the single case would always be valid.

It may be recalled that it is precisely because of the variability of human behavior that the single case is important as is argued by Allport and by Horst. It is curious that the fact of variability of human nature seems to be used by McNemar as indicating the need for the statistical method, while for Allport and Horst the same fact is seen to require the single case method.

In relation to control of human behavior as one of the aims of science, Allport seems to be on weaker ground with respect to demonstrating that control falls within the realm of science rather than of art, at least it seems so to the present writer. It is very true that the idiographic approach is necessary in relation to control, and perhaps even more necessary than in the case of the other aims of science. As Allport states:

Psychological therapy proceeds largely upon the case basis. The arts of medicine, social work, counseling, require the practitioner to individualize his general knowledge and to adapt it to the special case. Here the interaction between nomothetic and idiographic understanding is essential. Nor should we forget the importance of the case document in helping the therapist keep in line with the social standards by which his work is to be evaluated. In a democratic society the therapist is required to advance the

welfare of the person: personal documents tell him wherein this welfare consists. (64, p. 161)

However, it is very strange that Allport uses the term "art" in connection with his discussion of therapy in view of the fact that one of the major points of his whole monograph is to show that the individual case as related to human documents can be subjected to scientific methods. This bit of inconsistency on Allport's part indicates that he is not too certain about including control as part of science. Also, the reference to the welfare of the person in the above quotation indicates that therapy falls, to at least a certain extent, within the realm of ethics which is usually regarded as outside of science. In fairness to Allport, it should be noted that he would admit, perhaps, that therapy today is an art more than a science but that his interest was in developing ways of making it more scientific in the sense of improving present methods of therapy which are too heavily based upon common sense knowledge. The question of whether this can be done remains to be seen, but the question of whether it should be done on theoretical grounds seems a vital one at present.

##### 5. The Issue of the Psychometric Versus the Clinical Approach

The single case issue sometimes appears in the form of a more specific issue in clinical psychology, namely the issue of the psychometric versus the clinical approach. The

psychometric approach represents the nomothetic view and an attempt to define clinical psychology in strictly scientific terms. The clinical approach represents the idiographic view and stresses the importance of the individual. It does not tend to insist on strictly scientific methods. P. E. Vernon (68) has a brief but adequate statement of the situation and one on which R. B. Cattell (69) and F. C. Thomas (70) are in agreement even though they are in opposition to Vernon on the issue itself. Vernon states:

The psychometric approach is characterized by two essential features: (1) rigid standardization of the testing procedure, together with empirical proof of reliability and validity, so as to eliminate the uncertainties and the bias inherent in more subjective methods of assessing human beings; (2) the conception of traits or abilities as discrete variables, whose variation among different individuals are purely quantitative. No reliance is placed on subjective ideas of the nature of human traits; their existence as true "vectors" of the mind should be established by the methods of factorial analysis. (68, p. 100)

The clinical approach, on the other hand, is characterized according to Vernon by its emphasis on the importance of regarding the individual as unique and therefore requiring qualitative, subjective, or intuitive understanding. The clinical approach is concerned with meanings and values and is interested in total personality. Furthermore, the clinical approach implies a concern not only with diagnosis but also with treatment.

Vernon's position in the matter is that "both approaches are legitimate and valuable, and they should reinforce rather than exclude one another." (68, p. 99) He is, however, regarded as a champion of the clinical method because he attempts to point out its advantages, while R. B. Cattell (69) is regarded as a champion of the psychometric method, and F. C. Thomas (70) attempts to take an adjudicating position but admits a bias in favor of Cattell's viewpoint as a result of his training in psychology. Both Vernon's and Cattell's arguments seem to be too bound up with the question of the value and validity of the Stanford-Binet type of intelligence test as distinct from a type of intelligence test that would be built upon more solidly grounded statistical methods so that the issue of the psychometric versus the clinical approach seems to become lost. One may well agree with Cattell's arguments against the Binet type of test and for the establishment of a more valid testing instrument based upon more modern statistical concepts and methods without thereby agreeing with Cattell's negative view toward the clinical approach. To agree that a particular type of test can be improved or that all tests should be improved is no argument against the clinical approach.

It should be recognized also that one of the most essential and significant aspects of the controversy, as Cattell himself points out, is that it involves the

broader theoretical or systematic issue of the value of Gestalt versus an atomistic sort of psychology. Cattell quite candidly takes an atomistic view even though he acknowledges that the validity of such a view has not been established with any great degree of certainty. He believes, however, that the atomistic view offers a less pessimistic philosophy and, at least, offers the possibility of a partial understanding of personality on an empirical and scientific basis.

Confirmation of Cattell's insight that the larger issue of Gestalt versus atomistic psychology is involved in the psychometric-clinical issue may be seen in the following bit of testimony given by Terman\* as quoted by Allport:

The clinical approach is absolutely necessary for the investigation of personality as a whole, for a true picture of personality cannot be pieced together from any number of test scores. The total is an organismic not an additive, total. (64, p. 145)

This statement of Terman is especially interesting in the context of the present discussion because Terman is so likely to be regarded as favoring the psychometric approach by virtue of his work with the Stanford-Binet. Also, it is interesting to note that Terman is in agreement with Vernon which would almost seem to indicate

---

\* Terman, L. M. "The Measurement of Personality," Science, 1934, 80, pp. 605-608.

that the Stanford-Binet type of test requires the clinical approach beyond any doubt even though Cattell's question about the value and validity of the test may still be raised. If one uses the Stanford-Binet type of test, the clinical approach is required, though it may still be asked whether the clinical approach is necessary when some other type of test is used.

In addition to pointing up the Gestalt-Atomistic issue in relation to the psychometric-clinical issue, Cattell indicates that the issue of art versus science is also involved. His position on this matter is that the validity of the scientific methods is well established especially in relation to the scientific test instruments themselves, while the validity of the artistic methods are well established in relation to the application, use, and interpretation of these test instruments. Cattell definitely provides a place for art, his only objection being to the use of artistic skills in the actual construction of and development of what are or should be scientific test instruments.

Cattell also recognizes the validity of artistic methods in therapy, especially in psychotherapy, which involves suggestion and transfer phenomena. He attempts to avoid the use of psychotherapy that involves transfer phenomena, however, in order to avoid using artistic methods. He favors a purely environmental therapy on the



assumption that it does not depend on transference since the therapist does not personally enter into the situation. It should be pointed out, however, that most genuine psychotherapy does and must actually involve transference to some extent. Even where the therapist is personally involved, Cattell believes that the psychometric method makes for more objectivity which, for him, is a primary consideration. He concludes the whole matter with this statement:

In short, psychology as a practical art is no less of an art, but rather a far more refined art, through being based on a more extensive scientific foundation.  
(69, p. 129)

A further fundamental issue involved in the psychometric-clinical controversy is pointed out by Cattell, namely, the question of whether psychology is wholly a natural science in the same sense that physics is a natural science. As this question was discussed in Chapter II, it is only necessary to note that Cattell's position involves the belief that psychology is a natural science in a complete way or that, at least, it should strive in that direction. At any rate, he is opposed to the intuitionist position which he sees as requiring a definition of science in cultural and social terms. The intuitionist relies on empathy, while the objectivist relies on observation and mathematical formula.

The views of E. Zilsel (71), a modern scientific empiricist interested in the development of scientific

methods, on the question of empathy in psychology are of interest here. Zilsel definitely accepts empathy as a necessary and important method of gaining psychological knowledge, while Cattell, as noted above, like many psychologists who believe that psychology should be a natural science, discards empathy as unscientific. Zilsel's justification of the method of empathy is related to his arguments for the validity of the concept of unconscious mental processes. He regards the latter concept as valid despite the apparent contradiction in terms that seems to be involved when mind is viewed empirically as equivalent to awareness. He writes:

When an individual acts in a certain way because of some past experience which is perfectly well remembered by him but is so disagreeable that he does not like to speak of it, and when another individual has "repressed" an extremely painful experience so that it becomes entirely "unconscious," both kinds of behavior can greatly resemble each other. The similarity becomes manifest in the fact that the observer can put himself psychologically in the place of both persons by means of empathy. The very possibility of empathy in both cases is the link by which conscious and unconscious processes are connected. This is the empirical reason why we are justified in using psychological terms and psychological methods in investigation of the unconscious. (71, p. 80)

It is the fact or principle of empathy that makes it possible to view unconscious processes as psychologically valid. Conscious and unconscious phenomenon become capable

of being understood as subject to kindred laws which, however, are different from physiological laws. Zilsel further remarks about the validity of the concept of unconscious, as follows:

The unconscious elements of mind have been introduced into psychology in order to fill the gaps of its causal explanations and to complete the domain of validity of psychological laws. This method of completing the scientific domain is entirely legitimate and is used in the physical sciences as well. Astronomers, for example, do not hesitate to discuss multiple stars with partly bright and partly dark components. Psychology of unconscious mental phenomena is not less empirical than astronomy of invisible stars. (71, p. 81)

It is well to note that Zilsel is not so naive as to be unaware of the dangers of empathy as a method of science. The dangers arise out of the fact that empathy is dependent upon the observer's own experiences--this is the subjective element that Cattell has in mind. Zilsel, therefore, maintains that predictions based upon empathy, "may be relied on only in so far as they are confirmed by observable actions and reactions of the individuals concerned." (71, p. 81) He further states;

The method of empathic interpretation may be used in scientific psychology as a preliminary heuristic tool. Certainly, it is fruitful if its results are tested later by observations of the perceivable behavior. But it is highly fallible, and the scientific content of all assertions obtained in this way consists solely in those components which can be confirmed by observation. . . . (71, p. 81)

6. The Psychometric Versus the Clinical Issue with  
Special Reference to Diagnostic Testing and Projective Techniques

The issue of the psychometric versus the clinical approach takes on a different aspect when related more specifically to the problem of diagnostic testing and to the use of projective techniques for diagnostic purposes. It is fairly clear that when confronted with the clinical problem of diagnosis, the psychometric approach yields a less adequate and less complete diagnostic picture than the clinical approach. The actual clinical problem of diagnosis seems to require more than quantitative test measurements. Stated somewhat less dogmatically, the psychometric approach fails to make use of the opportunity to obtain clinically valuable information and diagnostic data over and above the information obtained from the test results in themselves. As C. M. Louttit (72) points out:

Psychological tests of almost every kind may be considered to make at least two major contributions; (1) they provide a quantitative measure of performance, and, (2) they afford an opportunity to observe the child's behavior under relatively standard conditions--at least the individual tests to this, (72, p. 84)

The psychometric approach simply fails to profit by the second contribution which a psychological test can offer, as mentioned by Louttit. It is restricted to the quantitative test results, so that diagnosis can only be made in those terms. The clinical approach on the other hand,

stresses the qualitative aspects of behavior that may be observed in test performance, and tends to regard the test as providing a more or less standardized interview situation which allows for the observation of behavior. Louttit (72, pp. 86-89) offers several illustrations of the value of this aspect of the clinical approach over the psychometric approach from the point of view of adequacy and accuracy of diagnosis. Also from the point of view of diagnosis Louttit emphasizes several important facts about the use of tests which imply the clinical approach, namely, (1) that quantitative test results must be interpreted in the light of the total behavior picture presented by the patient, (2) that no single test is intended to measure everything about an individual, and (3) there are many inevitable subjective factors which partly determine the test score and which therefore must be evaluated qualitatively.

The concept of regarding psychological tests as providing a standardized interview situation which allows for the observation of individual behavior and which implies the clinical approach is probably derived from the concept which forms the basis for projective tests. In fact, it is a generalization of the concept basic to projective tests and has been called by D. Rapaport (73), the projective hypothesis. That projective tests themselves seem to imply and involve the clinical approach is thus not surprising.

In a sense, however, projective tests represent a compromise of the psychometric-clinical approaches in that they attempt to obtain the vital and individualized data usually obtained in the clinical interview, and also the same sort of objective data usually obtained from the more conventional psychological test. This observation about projective tests seems to be substantiated by the historical fact that they originated from both a psychiatric and an academic psychological background--a fact pointed out by H. Sargent (74). According to Sargent, the term projective methods as applied to projective tests was first used by L. K. Frank in an article written in 1939\* though many of the tests themselves were used prior to that time. In discussing the historical and theoretical background of the projective methods, Sargent notes:

. . .three major theoretical trends which have contributed to a general point of view, and four lines of research more or less closely related to projective experimentation. The most important theoretical influences include psychoanalysis, global theory, and certain developments in twentieth century general science. Relevant research includes studies in imagination and phantasy, the word association method, investigation of language, and the development of methods for the use and interpretation of personal documents. (74, p. 258)

---

\* Frank, L. K. "Projective Methods For The Study Of Personality," J. Psych., 1939, pp. 389-413.



In discussing the first mentioned of the theoretical influences which formed the "theoretical climate" for the projective methods, namely, psychoanalysis, Sargent regards the mechanism of projection as one of the most readily understood and accepted of Freud's notions. Her review of the literature leads her to make a distinction between the noun projection as describing one type of ego-defense mechanism, and the adjective projective which broadly describes the effects of this type of projection and other psychic processes as well as the methods--the projective methods--used to elicit and study these projections. Sargent further points out that it is not only with respect to the specific mechanism of projection that projective methods are indebted to psychoanalysis but with respect to all of the theories and methods of psychoanalysis in general.

The second of the theoretical influences mentioned by Sargent as forming the background of projective methods, namely, global theory, points directly to the fact that projective methods depend upon the clinical rather than the psychometric approach. As Sargent points out the period in which the projective methods were developed is pervaded by a revolt against atomism--an atomism manifested in the field of personality by a concern with so-called objective measuring instruments. In opposition to atomism, the projective methods were formulated in terms of what is

variously called the global, the holistic, the organismic, or the field-theoretical systematic viewpoint. The link between global theory and projective methods may be seen in the fact that the projective methods seek to study personality as a whole, and in action as a dynamic, functioning manifestation of human behavior rather than as a dissected, static, and therefore distorted set of elements or parts which may later be summed up by a simple additive procedure. The interest in the projective methods as touching upon the organizing processes of personality--the ways in which the personality organizes experiences--also stems from Gestalt theory.

The third of the theoretical influences mentioned by Sargent in the background of projective methods are those which grew out of twentieth century developments in science. The reference here is to the new approaches to science demanded by the findings in relativity physics. In the first place, psychology can find a sanction in modern general scientific theory for an interest in the individual as such. Sargent quotes L. K. Frank\* in this connection:

Theoretical physics has adjusted itself to the conception of a universe that has statistical regularity and order, and individual disorder, in which the laws or aggregates are not observable in the

---

\* Frank, L.K., "Projective Methods For The Study Of Personality," J. Psych., 1939, pp. 389-413.

activity of the individual making up these aggregates. Thus, quantum physics and statistical mechanics and many other similar contrasts are accepted without anxiety about scientific respectability. The discrete individual event can be and is regarded as an individual to whom direct methods and measurements have only a limited applicability. We can therefore acknowledge an interest in the individual as a scientific problem and find some sanction for such an interest.

(74, p. 261)

The general idea of studying phenomena which are not directly observable by observing such phenomena in terms of their reaction to certain media stems from methods used in modern physics, according to Frank. In physics, for example, the electric current and polarized light are used as media for determining the composition of certain substances by noting their effect upon these media. Personality is not directly observable but it can be understood as an organizing process as it is revealed through its reaction to meaningless and relatively formless material such as an ink-blot or a piece of clay.

Confirmation of the contention that diagnosis involves the clinical rather than the psychometric approach may be gained from the following statement of B. Klopfer, a well known clinician:

The clinical psychologist started his role in the field of personality diagnosis of children as a psychometrician. The really experienced and wide awake clinical psychologist never limited his field of vision to quantitative measurements but paid as much attention to the

qualitative analysis of whatever test he used as he did to its quantitative results. However, in many medical institutions the very existence of the I.Q. lends itself to the danger of relegating the function of the clinical psychologist to that of laboratory technician. He is there simply to add I.Q. and other quantitative data to the blood count, the urine analysis, and all other entries on the medical chart. The disadvantages of this dissective or purely summative approach to diagnosis have been equally present and palpable in both medical and psychological work. Both the development of a more dynamic concept of personality and the new movement of psychosomatic medicine have come into use as reactions against this danger. (75, p. 89)

Further evidence that diagnostic testing involves the clinical rather than the purely psychometric approach may be seen in the statement made by D. Rapaport in the introduction to his recent book on diagnostic testing. In discussing the psychological rationale of the tests reported on in the book, Rapaport writes:

In order to develop a psychological rationale for these tests and the types of responses on them, we adopted the "projective hypothesis"--namely, that every reaction of a subject is a reflection or a projection, of his private world. This approach to testing contrasts sharply with that usually characterized as "psychometric." The main aim was not to attribute to a person a percentile rank in the population or any other numerical measure allegedly representative of him. The aim was rather to understand the individual; to give him a chance to express himself in a sufficient number and variety of controlled situations, the nature of which has been well enough explored to enable the psychologist to

infer out of the subject's reactions, the gross outlines of his personality makeup. This expectancy, however, implies the "projective hypothesis;" it implies that every action and reaction of a human individual bears the characteristic features of his individual makeup. . . .

The projective approach is not concerned with the numerical percentage or age equivalent which, in the average population, corresponds to the subject's performance; its concern is to reconstruct out of features of the subject's reactions, or relationships of features in the subject's reactions, the specific individual dynamics in the living subject. Nevertheless, we did not take the usual attitude that in such cases statistical work is useless and unnecessary. We applied statistical procedures because we believe that they put clinically-discovered relationships into easily communicable and reasonably convincing form. We did not, however, take the stand that what one cannot prove statistically is not significant or true. (73, p. 10)

Rapaport indicates at several points that he regards his approach to diagnostic testing via the projective hypothesis as representing an attempt to "bridge the gap between the traditionally lifeless numerical test results and the living clinical dynamics" (73, p. 11); or, as a compromise of the psychometric-clinical approaches insofar as it takes account of the clinical and theoretical findings of modern dynamic psychiatry and at the same time employs scientific methodology. This view of projective tests, mentioned earlier in the present discussion, seems to be the most tenable one with regard to the issue of the psychometric versus the clinical approach. To close ones



eyes to vital clinical material in an effort to be scientific and quantitative is to sacrifice too much, while to deny the value of scientific methods in an effort to take account of vital clinical material is to be equally shortsighted. The projective methods represent an attempt to solve this dilemma.

The significance of the findings of the inquiry into the psychometric-clinical issue, especially in relation to diagnosis as discussed thus far, may now be indicated with respect to the larger question of whether clinical psychology is an art or a science. As T. R. Sarbin (76) aptly points out, there is need for clarification of this question because the manner in which the training of future clinicians is carried out, and the basis and interpretation of research are both greatly dependent upon whether clinical psychology be considered an art or a science.

Sarbin's answer to the question is consistent with his views on the single case and on the clinical approach. As was seen above, Sarbin denies the validity of the single case and also of the clinical approach, so it is not surprising that he denies the validity of all but strictly scientific methods for clinical psychology. For Sarbin it should be recognized, scientific method is rather narrowly conceived in terms of being wholly and adequately characterized by a concern with prediction carried out on the basis of statistical concepts.



Sarbin's argument proceeds by first pointing out that diagnosis and treatment are the chief functions of clinical psychology. Diagnosis is then analyzed to determine whether it is essentially artistic or scientific. He finds that clinical diagnosis as distinct from ordinary or mere literary description always involves description with a future referent; diagnosis involves prediction and usually implies prognosis. His concluding statement in this connection is:

It is submitted, then, that a diagnosis, to be meaningful, must be predictive, and that predictions are the result of statistical generalizations. Since prediction is considered the hallmark of science, we may safely conclude that diagnosis is a scientific enterprise.

(76, p. 394)

For Sarbin diagnosis simply involves prediction which in turn is based upon ordering an event to a class of events in terms of the principles of probability and statistics. This is strictly a mechanical procedure and employs nothing that partakes of the nature of an art. If, on the other hand, diagnosis is regarded as involving something more than mere prediction in Sarbin's sense; if diagnosis involves an appraisal of the dynamics of a particular personality pattern; if diagnosis requires a point of view similar to that of C. M. Louttit, D. Rapaport or any of the other clinicians mentioned as supporting a clinical approach as distinct from a psychometric approach--

if all this be true, then diagnosis cannot be considered as a strictly scientific enterprise. Diagnosis involves artistic as well as scientific methods. This means that clinical psychology must be considered an art as well as a science insofar as diagnosis is one of the chief functions of clinical psychology, and insofar as diagnosis involves artistic as well as scientific methods.

It is important to note further that even if Sarbin's view that prediction is the central meaning of diagnosis be adopted, a wider view of what is involved in prediction is still possible. P. Wallin (66), for example, in discussing the skills and characteristics of the successful predictor points out the two major viewpoints as to the nature of the skills required of the predictor. There is, first, the view which stresses conceptual analysis, and second, there is the view that stresses the non-analytical modes of understanding including such things as sympathy, empathy, intuition, and insight. Wallin's position with regard to these more or less opposite viewpoints is that both modes of understanding--the analytic and non-analytic--are important and valid. He points out that all of the non-analytic modes of understanding take on the quality of being an art rather than a science so that they have received little empirical confirmation in the sense of experimental proof of their efficacy. The lack of empirical proof, however, Wallin points out, does not justify denial

of their validity. An open-minded attitude which recognizes the validity of both forms of understanding seems more fitting at the present time, according to Wallin.

### 7. The Meaning of "Clinical" in the Definition Of Clinical Psychology

The meaning of the term "clinical" has been indicated mostly in an implicit manner in the preceding presentation of controversial material although explicit reference to the significance of the clinical approach has been made to some extent. For example, the essence of the clinical approach lies in its concern with the single case, and with particularizing observations and knowledge from the standpoint of understanding the individual as a unique personality. In order to gain a broader basis for comprehending the full significance of the term clinical, it is pertinent to view it historically and to examine some of the definitions that have been proposed by various clinical psychologists at various times and places.

Lightner Witmer founded the first psychological clinic in 1896 at the University of Pennsylvania. The history of that singularly outstanding achievement is reviewed by S. W. Fernberger (77) against the background of the developments in the general and experimental psychology of that era. C. M. Louttit (78) definitely establishes Lightner Witmer as the founder of clinical

psychology with the following statement:

In spite of Cattell's<sup>\*</sup> recollection, at a much later date, that he (Cattell) tried to start a psychological service for students of Columbia during "the middle of the nineties" and Fernberger's<sup>\*\*</sup> statement that, if Witmer had not inaugurated clinical psychology, someone else shortly would have, it would appear that Witmer alone must be given the credit for the establishment of the clinical type of psychological application. (78, p. 362)

The immediately influential development in general psychology which fostered Witmer's founding of clinical psychology was, as Fernberger (77) indicates, the estimation of individual differences and variation on the basis of statistically established norms in respect to traits or abilities. This has since come to be known as the psychology of individual differences and it must be noted that J. M. Cattell who is mentioned by Louttit above does deserve at least indirect credit for founding clinical psychology because he was Witmer's teacher and Fernberger points out that Witmer was early influenced by Cattell's strong interests in individual variability.

The scope of Witmer's clinic was broadly conceived in the sense that Witmer was interested in normals as well as abnormals, and in that he was interested in developing

---

\* Cattell, J. M., "Retrospect: Psychology As A Profession," J. Consult. Psych., 1937, pp. 1-3.

\*\* Fernberger, S. W. (77)

practical techniques as well as in research. From a more recent standpoint, however, Witmer's clinic was limited in that it dealt in educational problems (in the narrower sense) and with the school child almost exclusively. In 1907, Witmer founded a journal, The Psychological Clinic, in which to set forth his ideas and stimulate an interest in the field of clinical psychology. It was in an early paper appearing in that journal that he first introduced the term and defined his concept of clinical psychology. He writes:

The phraseology of "clinical psychology" and "psychological clinic" will doubtless strike many as an odd juxtaposition of terms relating to quite disparate subjects. While the term "clinical" has been borrowed from medicine, clinical psychology is not a medical psychology. I have borrowed the word "clinical" from medicine, because it is the best term I can find to indicate the character of the method which I deem necessary for this work. Words seldom retain their original significance, and clinical medicine is not what the word implies--the work of a practicing physician at the bedside of the patient. The term "clinical" implies a method not a locality. . . .  
(77, p. 350)

It is a method, Witmer goes on to point out which is characterized by its emphasis on the importance of dealing with the individual case:

The clinical psychologist is interested primarily in the individual child. As the physician examines his patient and proposes treatment with a definite purpose in view, namely, the patient's

cure, so the clinical psychologist examines a child with a single definite object in view--the next step in the child's mental and physical development . . . . (77, p. 351)

It is important to emphasize that Witmer did not limit his concept of clinical method to one which dealt with the abnormal child exclusively. In this connection, the following statement may be quoted:

I would not have it thought that the method of clinical psychology is limited necessarily to mentally or morally retarded children. . . . Indeed, the clinical method is applicable even to the so-called normal child. For the methods of clinical psychology are necessarily invoked wherever the status of an individual mind is determined by observation and experiment, and pedagogical treatment applied to effect a change, i.e., the development of such individual mind. Whether the subject be a child or an adult, the examination and treatment may be conducted and their results expressed in terms of the clinical method. (77, p. 351)

In this last statement Witmer indicates a broader view of clinical psychology than he was actually able to put in practice in his clinic which, as was already indicated above, was limited to dealing largely with the school child.

Another event of great significance in the history of clinical psychology which C. M. Louttit (78) mentions in his brief survey is the publication of the Binet-Simon



scale in 1905\*. This ushered in the mental testing movement which became so strong as almost to overshadow clinical psychology. Mental testing tended to take the place of clinical psychology in the sense that the administration of standardized tests in a more or less mechanical fashion became the only contribution of the clinician. Louttit writes:

While neither Binet himself, nor any of the early clinical psychologists, ever claimed miracles for standardized tests, the inevitable result ensued, and persons with a knowledge of tests--or even one test--began to offer themselves for, and were employed in positions where only sound clinical training and experience were really valuable. While to follow all the possible results of this attitude would take us too far afield, we must point out that this is the essential basis for the widely held belief that clinical psychology and mental testing are the same activity.

(78, p. 364)

Louttit's feelings on this subject are so strong (as are those of all clinicians who favor a broader view and concept of the nature of clinical psychology) that he refers to the "dark ages of mental testing" as having retarded the growth of clinical psychology. There was a host of other influences and events, however, such as the development of dynamic psychiatry, the mental hygiene

---

\* Binet, A., & Simon, T. "Méthodes nouvelles pour le diagnostic du niveau intellectuel des anormaux." Année psych., 1905, 11, pp. 191-336.

movement and the child guidance movement which tended to enrich clinical psychology. Louttit is able to factor out the following list of common characteristics which emerged from the early history of clinical psychology:

1. The interest was rather definitely with children.
2. Children with behavior deviations were the primary concern.
3. The methods used emphasized a well-rounded study of the child as a physical, social, and psychological individual.
4. Diagnostic study was not an end in itself, but a starting point in a reeducational, corrective, or therapeutic program. (78, p. 366)

After examining a collection of approximately forty definitions of clinical psychology, Louttit classifies them into four specific categories. The largest group of definitions seem to be in line with the Witmer position with its emphasis on the study of the individual. Louttit quotes definitions given by R. A. Brotemarkle, M. S. Viteles and E. A. Doll as following and elaborating the Witmer teachings. The definition formulated by a Committee of The American Psychological Association, Clinical Section, is a high point in the Witmer tradition and may be regarded as a semi-official definition as of 1935. It follows:\*

---

\* American Psychological Association, Clinical Section. The definition of clinical psychology and standards of training for clinical psychologists. Psych. Clin., 1935, 23, pp. 2-8.

Clinical psychology is a form of applied psychology which aims to define the behavior capacities and behavior characteristics of an individual through methods of measurement, analysis, and observation; and which, on the basis of an integration of these findings with data received from the physical examinations and social histories, gives suggestions and recommendations for the proper adjustment of the individual.

(78, p. 368)

A second group of definitions are those which tend to render clinical psychology synonymous with psychometrics. There is some historical basis for this type of definition that makes it seem reasonable, but relatively few clinical psychologists adhere to so narrow a view at the present time. This type of definition would hardly be worth considering, as Louttit aptly points out, were it not for the fact that many psychiatrists, social workers and other professional as well as lay people tend to accept such a definition.

A third category also has a historical basis. It is made up of those definitions which would limit the functions of clinical psychology to those concerned with the abnormal or the deviate personalities. This type of definition was held by the earlier clinicians like H. H. Goddard in connection with his work on the feeble-minded, and by J. E. W. Wallin in connection with his work on the exceptional child.\* It is not surprising to find that the

---

\* Gesell, A., Goddard, H.H., & Wallin, J.E.W., "Field of Clinical Psychology as an Applied Science," J. Appl. Psych., 1919, 3, pp. 81-95.

early clinicians tended to frame their definitions of clinical psychology in conformity with their particular major interests which were at that time bound to be narrow. As Louttit points out, however, their more recent statements tend to express a broader viewpoint.

A fourth classification includes those definitions which emphasize the medical aspects of clinical psychology and tend to regard it as a branch of medicine or as a medical specialty. Louttit criticizes this type as representing either a personal bias or a lack of insight into the essential nature of clinical psychology. By way of summary, he states:

Clinical psychology is not psychometrics; it is not medical psychology, nor does it deal primarily with the sub-normal or abnormal. The field includes all of these, but it is broader than any of them. (78, p. 370)

Louttit indicates that his own view is that clinical psychology is an art and that it involves not only the application of one or two basic sciences but of many sciences. Its successful practice involves not only psychology but also sociology, medicine and education as well as any other field of knowledge which can contribute to a meaningful description of the individual. Its successful practice involves evaluation of the individual in terms of personal and social acceptability and the development of methods for changing the individual regarded as unacceptable.

This brief historical summary of definitions has served to confirm the conclusion that the essence of the clinical concept lies in its concern with the individual. Several significant observations may now be added: (1) Its concern is not limited to any single type of individual either with respect to age or normality. (2) It is concerned with understanding the individual through the application of many forms of knowledge and within as broad a framework as seems required to achieve a complete understanding of the individual. (3) It is concerned, however, not simply with understanding but also with influencing or changing the individual in terms of the existent personal and social values.

## Chapter IV

### CLINICAL PSYCHOLOGY AS A PROFESSION: THE ETHICS OF CLINICAL PSYCHOLOGY

#### 1. General Plan of the Chapter

In previous chapters, the concern has been with some of the problems and issues involved in understanding clinical psychology in terms of science and art. Thus far, it appears that clinical psychology cannot be defined completely in terms of either science or art. It becomes apparent, further, that clinical psychology cannot yet be completely defined even though both the concepts of science and art are employed, for, in addition to being both a science and an art in particular aspects, clinical psychology also constitutes a profession. In order to realize the meaning and significance of this something more than science and art must be taken into account; (the concept of profession obtains meaning largely in terms of the principles of ethics) so that many of the problems involved in understanding clinical psychology as a profession are intelligible only from the standpoint of their relationship to ethics.

An attempt is made here to demonstrate briefly the meaning and significance of ethics in relation to clinical psychology. This is done with the intention of providing an appreciation for a realm of discourse the



relevancy of which often has been overlooked by clinicians, probably as a result of their zeal to be thoroughly scientific. These considerations of ethics should provide also an introductory background for the more specific consideration of the concept of profession, the related problems of standards of professional achievement, training, and the issue of certification. The orientation will always be definitely toward understanding the specific problems of clinical psychology as a profession so that many problems such as those centering around the ethics of psychotherapy will present themselves. Nevertheless, the attempt will also be to bring the principles of ethics, or the viewpoint of ethics, to bear wherever it seems possible to integrate it with what appears to be the requirements of an effective clinical psychology.

## 2. The Meaning and Significance of Ethics in Relation to Clinical Psychology

The immediate reaction of many clinical psychologists to the suggestion that clinical psychology be understood in terms of ethics would unquestionably be a strongly negative one. Even those who as experienced clinicians are sophisticated enough to talk about clinical psychology in terms of art as well as of science would probably balk at the suggestion. The naively positivistic viewpoint that clinical psychology must be solely concerned

with an objective and wholly impartial search for causation, or with the attainment of a full understanding that is nonetheless somehow completely divorced from any subjective influences in any sense still pervades the thinking of many clinicians. The clinician seems to be caught up in a certain ideology of our culture that places an extremely high value on science and tends to depreciate everything that is not science. In so doing the actual facts are likely to be overlooked; all forms of knowledge and practice are formulated in terms of science with the result that those problems which actually involve non-scientific forms of knowledge are not fully grasped and are poorly handled.

Several ways in which clinical psychology involves ethics have already been indicated at several places in this study (Chapter II). In the first place, clinical psychology involves ethics insofar as it is concerned with human behavior which by its very nature cannot be understood without reference to values. The views of J. C. Flugel on this subject may be added here by way of confirmation of those cited earlier. Flugel (79) points out that most psychologists prefer to think of psychology in positivistic and non-normative terms as being chiefly concerned with the facts of mental life. Nevertheless, psychology differs from the physical science where such a viewpoint may be valid. As Flugel states:

Values happen to be facts of mental life, and psychology, since its task is the study of mental life, is also concerned with the examination of values as parts or aspects of this mental life. In this respect it differs from physics and chemistry, which are not thus directly brought into contact with values in any part of their field, since value does not appertain to matter as such.

(79, p. 11)

Flugel also makes a point that was brought out earlier in the discussion of the distinction between pure and applied science, that psychology as an applied science involves reference to an ethical ideal in that it implies goals or ends other than mere knowledge or truth for its own sake. All this means that clinical psychology must be concerned with values, and that the concepts, principles and methods of clinical psychology must be governed by value judgments as well as by judgments based on facts and objective findings.

The concrete implications of this may be seen in relation to the problem of diagnosis. The psychologist has many testing instruments at his command which may reveal a great deal about an individual's intellectual and emotional make-up. In themselves the instruments are nothing more than just that, but when used in connection with human beings and human behavior they become much more than instruments. The purposes for which they may be used are highly variable, and even more important, these purposes definitely have a tremendous effect upon the instruments which makes

them something different from mere objective instruments. The variety of aims with which instruments may be used extends all the way from those which grow out of placing the supreme value on the good of the individual himself to those which place the supreme value on some external agency which tends to exploit the individual.

Relative to the problem of therapy, it is even more patent that clinical psychology is concerned with values and that these values exert a controlling influence on concepts, principles and methods of psychotherapy. A. W. Green (80), for example, in a recent article points out that all psychotherapy necessarily involves social values and presents the thesis that since this is true, values should be dealt with explicitly and self-consciously rather than covertly. Green defines social values as, "standards of morality and conceptions of other's welfare, supported by the groups of which the given person is a part (80, p. 199)." Sociologically, social values, "comprise the matrix relating acts of individuals (80, p. 200)." Psychologically, social values are aspects of behavior derived from social forces and incorporated into the personality. While all behavior is not necessarily social, all behavior requiring psychotherapy is social in that it involves conflict over social values. Three sets of values should be recognized in psychotherapy, namely, (1) the therapist's, (2) the client's, and

(3) the person's and group's in the current social setting of the client. Green goes on to present a convincing argument showing that there exists a definite relationship between a given theory or school of psychotherapy (as, for example, the Freudian, or the adjustment school represented by some contemporary Americans), and the particular social values maintained by its proponents. A specific form or type of psychotherapy always involves specific kinds of social values.

Two main points then may be granted concerning the relation of ethics to psychotherapy. In the first place, psychotherapy in its most general and essential meaning involves influencing and changing behavior in some way and to some degree with reference to a particular social setting. This implies the problem of the direction that such change should take and this cannot be settled without reference to a set of values. Second, it is clear that social values determine the aims of therapy and that the aims of therapy in turn govern the principles and procedures of therapy.

Before proceeding further with the discussion of ethics it should be emphasized that the term ethics is being employed in its widest connotation, rather than in the sense of a concern with morals according to some particular and possibly narrow set of values. Perhaps those psychologists who react negatively to any suggestion of the connection

between ethics and psychology think only of ethics in this restricted sense. It is readily agreed that clinical psychology should avoid a concern with morals in this sense. This, of course, points to the whole problem of the relation of knowledge as such to ethics, or of cognition to emotional judgments on the personal plane of ethics because one may well ask such questions as: When is a set of values narrow? How can the factual knowledge available to clinical psychology be integrated with a set of values granting that both knowledge and values are important? How can cognition be integrated with orexis?<sup>\*</sup> In another form these questions point to a central problem in ethics, the relationship between means and ends. The present thesis is not concerned with these problems in ethics as such. It is necessary to stress, however, that clinical psychology cannot afford to avoid a concern with ethics on the assumption that such a concern involves a narrowly "moral" point of view which is inferior to a scientific point of view, nor can ethics be avoided on the grounds that the problems in ethics itself are extremely complex and difficult to solve.

It seems relevant to include a recent statement

---

\* The term orexis is the Aristotelian term meaning the feeling, striving, and wishing aspects of the mind and is used by J. C. Flugel following, as he says, many modern writers. (79, p. 14)



of an ethicist relative to the present state of ethics and a possible solution of some of its problems. G. L. Stevenson (82) regards the present state of ethics as highly confused methodologically and he offers a critical analysis of methodological principles as a prolegomenon to further ethical inquiry. Stevenson's position is that (1) ethics is a normative discipline, (2) it is not identical with science but uses scientific facts and goes beyond science in the sense that it has its own problems and issues but not in the sense of being based on a set of absolute or ultimate principles, and (3) ethics is concerned with evaluative propositions and/or statements which are descriptive as well as with non-descriptive statements, with cognitive as well as with non-cognitive statements, and with emotive as well as with non-emotive statements. Ethics is concerned primarily with attitudes and beliefs; it may be legitimately persuasive and/or imperative, and may also have legitimate emotional meaning.

Ethics, as may be gathered from Stevenson, seems to deal with the process of evaluating human conduct (both personal and interpersonal) from the standpoint of influencing, molding, guiding, and directing such conduct in relation to a set of focal aims. It is intimately and deeply concerned with attitudes and with beliefs from which attitudes may gain their support.

Clinical psychology seems to be strongly akin to what Stevenson describes as his concept of ethics in the

personal sphere. Like ethics, clinical psychology is not concerned primarily with the attainment of an understanding of psychological processes, but rather with the process of influencing, of changing, or of directing conduct. Like ethics it is concerned with emotional re-orientation and redirection of an individual not simply with understanding the mental life or the behavior of the individual for its own sake. The kinship is seen further in that they both draw upon many fields of inquiry--many sciences--for factual information and knowledge in order to establish in the case of ethics the beliefs which form the basis of ethical attitudes, and in the case of clinical psychology the basis upon which behavior may be controlled and changed. However, clinical psychology is not identical with ethics because clinical psychology in one important aspect does take on the character of a special science concerned with the study and understanding of psychological processes. The similarity is present only with respect to the practical, applied, or therapeutic functions of clinical psychology and with respect to the practical or applied aspects of ethics.

### 3. The Concept of Profession

Before the more specific problems basic to formulating a valid concept of profession applicable to clinical psychology are discussed, it may be helpful to

consider the problem of professional ethics in general.

C. F. Taeusch (83) states the problem as follows:

The situation which confronts us is this: in order to secure a desired amount of freedom in pursuing their vocations, men have become convinced that the law as an agency of public control is not adaptable to certain social purposes. This is so because any agency which, like the law, attempts to control the relations of a great number of people engaged in diverse interests, must be general in its scope. The moment that the law attempts to meet the requirements of the more complex social situations, it interferes unduly with personal rights and the prerogatives of any individual in a competitive society. Therefore, professional and business men have seen fit to organize fairly homogeneous groups in order to establish standards and rules within such a group. Codes have been formulated, practice committees organized, precedents established and sanctions determined. Here is a social phenomenon of the first order. Are we conscious of its implications and possibilities? What is the social philosophy involved?

(83, p. 12)

Taeusch goes on to point out the necessity for a definition of the concept of profession in order to understand the social phenomenon involved. He offers the following as his definition:

A profession consists of a limited and clearly marked group of men who are trained by education and experience to perform certain functions better than their fellowmen. (83, p. 13)

In elaborating this definition, Taeusch stresses the necessity for clearly delimiting the functions of a profession as a means of maintaining the standards and

responsibilities. He writes:

In general the standards of any profession are menaced if the line of demarcation between it and other activities is not clear, or if its members may indulge in highly profitable ventures in easily accessible alternative activities. (83, p. 15)

In connection with this point Taeusch uses the illustration of the wearing of the uniform in the wartime professional military. The uniform clearly marks and symbolizes the professional duties and responsibilities of the soldier and failure to wear the uniform becomes an offense of the first order. Taeusch argues that the situation in the non-military professions is comparable:

Every man owes it to his profession to indicate clearly what his business is, otherwise he has no right to the benefits accruing to the members of that profession. On the other hand, any profession which fails to insist on the identity of its members must take the consequences; the offenses of its marginal and ambiguous members react unfavorably on the profession as a whole. . . . (83, p. 15)

Another outstanding characteristic of professional activity as distinct from business pursuits is that it is controlled primarily by the ideal of service rather than of pecuniary gain, the latter being only a secondary consideration. Most writers on the subject of professional ethics make this distinction. This statement of R. D. Kohn (84) seems particularly clear:

The earning of a livelihood is naturally the result of competent practice of a profession. But that is not its prime purpose in the best sense. The prime purpose is the perfection of a service, and the most important reward of that perfection is, not the extent to which it is paid, but the extent to which the service is appreciated by those best competent to judge it, by those who practise the same profession. (84, p. 2)

Business is for profit and gain while professions are carried out primarily for rendering service to others; for the public interest, or public welfare. Professional activity may secondarily provide a livelihood but it is not on that account to be judged ethically good. Kohn recognizes that this professional ideal of service in the public interest is difficult to achieve in reality, and that there are stages of professional development through which professional organizations can go and actually have gone. The earliest stage of ethical development, Kohn indicates, is concerned with protection against unfair competition and improving the profession in the public estimation; the second stage stresses the relationships between the membership within the profession; the third stage attempts to develop standards of admission into the profession; the highest stage is reached when the service ideal is considered supreme even at the expense of the earlier and more self-centered considerations of professional rights and desires.

R. M. MacIver (85) also indicates the central importance of the service ideal as the distinctive mark of the professions and documents the point by reference to the codes of various professions. He writes:

They (the professions) assume an obligation and an oath of service. "A profession," says the ethical code of the American Medical Association, "has for its prime object the service it can render humanity; reward or financial gain should be a subordinate consideration," and again it proclaims that the principles laid down for the guidance of the profession, "are primarily for the good of the public." Similar statements are contained in the codes of the other distinctively organized professions. (85, p. 6)

It is valuable to cite the statement of L. J. Elliott (86) concerning the concept of profession as applied to social work because social work in 1931 when Elliott published her study was confronted with professional problems similar to those now facing clinical psychology.\* Elliott's statement contains most of the ideas already presented above. She notes that there is no clear-cut, complete agreement on the criteria for a profession, but after reviewing the various authorities, she finds it

---

\* Elliott's study should prove instructive for any attempt to formulate systematically professional ethics of clinical psychology because it represents an empirically yet soundly oriented attack on the problems involved in a profession whose status at the time (1931) was similar in many respects to the present status of clinical psychology.



possible to include social work as a profession. She writes:

If we define a profession as a limited group possessing a special body of knowledge acquired through education and experience, organized for the performance of a certain function, and at the same time emphasizing service rather than pecuniary gain, social work is evidently a profession. (86, p. 5)

Elliott's definition of a professional code and of professional ethics in general are also useful. She writes:

A professional code may be defined as a written expression of the ethical principles or rules of conduct for the guidance of a professional group, as adopted or drawn up by that group.

Professional ethics, we may then safely assume to be the system of ethical principles and rules of conduct generally accepted by the members of a professional group, whether or not these are formulated into a code.  
(86, p. 5)

Only recently have psychologists become sufficiently concerned about the problem of professional ethics to publish their ideas. Some of this literature may now be examined as a convenient way of considering the problems regarded as vital to-day.

A. Sutich (87) begins his article by pointing out that the consulting relationship implies a concern with

applied ethics whether this be generally recognized or not.\* The other more established professions like the legal and the medical have well developed codes of ethics which embody and express the ethics of those particular professions, and Sutich believes the time is ripe to develop a code of ethics for consultants. He suggests a code which is based upon the philosophy of non-directive psychotherapy as advanced by C. R. Rogers.\*\* He uses this philosophy as the basis for his code because he thinks it is derived from and built upon democratic principles of human relationships which principles are, of course, in turn believed to express the highest and most valid sort of ethics for modern life. His definition of democratic ethics, that is, of the rights, duties, and objectives of democratic ethics is as follows:

A democratic ethic, for example, may be defined as a formal structure of explicitly designated, equal, but not necessarily identical, individual and mutual, status, rights, duties, objectives, and conditions, mutually accepted and used as a guide to conduct by the respective voluntary participants in a relationship. Similarly, a democratic

---

\* Sutich and some of the other writers to be mentioned in this section use the term psychological consultant rather than clinical psychologist, but all of their ideas and statements are equally applicable to what the present writer regards as the generic discipline of clinical psychology. More will be said about this problem of terminology at another place.

\*\* Non-directive psychotherapy is discussed in Chapter V.

right is a permissible action which, by mutual agreement, may be exercised or not as desired, by one or more of the participants in a democratic relationship, provided such action does not conflict with any of the co-related conditions, rights, duties, and status of the participants. A democratic objective in a relationship is one which either states or implies a desire for the optimum satisfaction of an individual or mutual need that may or may not conflict with other needs, and which does not violate any of the co-related rights, conditions, duties, objectives, and status of the persons involved in its attainment.  
(87, p. 331)

It is on the basis of the above definition that Sutich builds his proposed code of specific rules of action in the consultant relationship. While his proposal should command serious thought, it seems questionable whether his belief in the democratic non-directive philosophy of psychotherapy necessitates some of the extreme rules of action and conduct he formulates. For example, one of his rules requires holding what he calls a non-judgmental attitude, meaning an attitude of withholding any moral judgments concerning the conduct and behavior of the client. Sutich seems to realize that the psychologist cannot escape completely from a judgmental role in that he bestows the psychologist with the right to terminate a consulting relationship or even to refuse to enter into a relationship in which the client, in the judgment of the psychologist, accepts or proposes to accept a non-democratic or

authoritarian objective. However, he does not seem to be aware of the fact that not only is the judgmental attitude inescapable but must always be assumed, a fact which should be clear from Sutich's own statement to the effect that a consultant relationship always implies ethical considerations. Sutich, in brief, seems to confuse an ethical issue with a point of psychotherapeutic technique when he proposes the rule regarding the necessity for maintaining a non-judgmental attitude. The validity of the psychotherapeutic technique of maintaining an attitude of acceptance toward the point of view, values, and beliefs of the client need not be questioned as providing the best method of obtaining a full understanding of the client and of helping him. This does not require that the psychologist put aside completely all of his own values and beliefs. Either implicitly or explicitly he is guided by moral principles and therefore expresses these principles within the consultant relationship notwithstanding adherence to the most radical kind of non-directive psychotherapy. Sutich's proposal to terminate the consultant relationship seems to be an effort to avoid the full implications of the ethics of the consultant relationship, and were it followed through would probably reduce the relationship to a very tenuous status, and thereby render it weak and ineffectual, for as soon as there appears any possibility of the necessity for exercising moral judgment, the psychologist

or the client would terminate the relationship. Actually the termination rule appears to require much qualification for it raises many problems both of an ethical and psychotherapeutic nature which Sutich apparently overlooks. It may well be asked, for example, whether the responsibility for the welfare of the patient can be dropped so easily or quickly merely because the patient happens to express some non-democratic ideas or because the psychologist seeks to avoid expression of moral judgment.

The difficulty involved in Sutich's attitude toward the expression of moral judgments is more evident with regard to his extension of the non-judgmental attitude to the scoring and interpretation of psychological tests. Here it is only logical to ask how tests which are based upon norms and standards can avoid being judgmental in their implications. Sutich seems to assume that they can.

Another rule proposed by Sutich which seems extreme and beyond the requirements of an ethics based upon democratic principles and of non-directive psychotherapy is the one that states it to be the duty of the psychologist to avoid an advisory role. This is consistent with the view on judgmental attitudes and seems to follow from the belief that the function of the psychologist should be purely and passively analytical as distinct from directly interpretive and advisory. It must be recognized

that it is a widely held principle among social workers, psychiatrists, and clinical psychologists that the method of simply giving advice of any nature is to be avoided as being an ineffectual, inadequate kind of therapy. This is so widely accepted as to be regarded as an axiom of unquestionable validity. Nevertheless, there are undoubtedly times and stages in the therapeutic process where the client would profit greatly from some form of advice that may be given by the psychologist who presumably does have a good deal of knowledge and experience about many matters that arise in the course of therapy. The careful technique and the deliberate way and timing with which such advice should be given cannot be overemphasized, and that it should not constitute the major basis upon which therapy is conducted cannot be gainsaid, but this does not require the complete avoidance of advice. There probably is no such thing as pure analysis or a passively analytical role in the therapeutic situation. Some conclusions will be arrived at as the result of analysis with respect to the past and future behavior of the client and at least a general form of advice or interpretation will always be implicit or explicit in these conclusions.

Another psychologist who has recently evinced an interest in the professional ethics of clinical psychology especially in relation to therapy is H. Sargent (88). She offers a critical discussion of Sutich's article though



she properly regards it as a valuable contribution if for no other reason than it raises the issue of professional ethics in psychology and because it raises many questions about the consulting relationship in relation to ethics.

Sargent agrees with the majority of the principles upon which Sutich's proposed code are based, but she believes that the therapeutic techniques implied in the formal phrasing of the code reveals a tendency to violate the principles of non-directive therapy as developed by C. R. Rogers. Both Sargent and Sutich accept the fundamental principles of the Rogers method, and both strongly believe that the principles and methods of psychotherapy which are employed in the clinical relationship should directly determine the sort of ethics to be followed. The implications of this are serious enough to warrant inquiry into how Sargent arrives at this position.

The initial premise is that the problem of ethics in professions like clinical psychology, psychiatry and social work is unique insofar as it is characterized by the fact that the client or patient enters into immediate personal relationship with the practitioner. This sort of personal relationship does not obtain in the case of other professions with the exception of most of the medical specialties which resemble psychiatry in this respect. From this fact of the existence of an immediate personal relationship in the clinical and therapeutic situation,

Sargent concludes that the ethical code adopted by the clinician or the consultant "must not only be acceptable in broad social terms; it must also conform to whatever practices and principles are essential to the therapeutic relationship itself (88, p. 47)." She goes even further and states:

None of its (the code's) formulations can be such as to interfere with the primary aim of consultation and treatment. If the purpose of consultation is to enable a client to use the situation for the solution of his problem, then our highest ethic must be the forwarding of that end. From the standpoint of society, the assignment of first place to the therapeutic purpose, over and above any value scheme, is justified in the conviction that growth toward maturity does itself lead in the direction of wiser social choice. . . . (88, p. 47)

It may well be agreed that the necessary existence of a personal relationship between client and clinician should exert an influence over the ethics adopted, but it may be asked whether this implies that the specific therapeutic principles and techniques employed in the therapeutic relationship should completely control the formulation of ethics. This radical position would seem to mean that all types of therapy other than non-directive inevitably lead to an invalid ethics. As R. F. Berdie remarks:

The ethics of the psychotherapist must not be confused with the technique of the psychotherapeutic method, as one author has recently done (Sutich).

Because a counselor believes a certain technique appropriate and advisable in a given case, he should not be called unethical. That is certainly professional authoritarianism. (89, p. 151)

To allow the principles of a specific school of psychotherapy to form the sole basis for a system of professional ethics seems likely to prove short-sighted and narrow both from the point of view of ethics in general and from the problems of psychotherapy which are still controversial and unsettled. In short, it is difficult to accept Sargent's extreme conclusion that the therapist has no duties other than those connected with the mastery of non-directive techniques which enable the client to express freely his feelings and gain insight into the process of his struggle for self-direction. It must rather be recognized along with R. Bixler and J. Seeman (90) that codification based upon the details of a specific kind or school of therapy is doomed to failure at present simply because clinical psychology is in a relatively early stage of development.

Bixler and Seeman present some of their own suggestions for a code of ethics from a broader standpoint, and in terms of the need to clarify responsibilities toward the client, toward psychologists themselves, toward other professions and toward society in general. They believe, moreover, that a genuine code of ethics must

stem from a philosophy--from a set of values--and that essential agreement on these must be reached before a code can be built. It is with a consideration of these values and the principles of action to which they give rise that they are concerned. They turn to H. C. Hand\* for a synthesized statement of values which are rooted in our culture and which they believe have stood the test of time. Hand's relevant postulates are quoted as follows:

The belief that human life, happiness, and well-being are to be valued above all else.

The assertion that, within limits imposed by nature, man is master of his own destiny; that within these limits man has the right to control his own destiny in his own interests, and in his own way.

The determination that the dignity and worth of each person shall be respected at all times and under all conditions.

The assertion of the right of individual freedom; recognition of the right of each person to think his own thoughts and speak his own mind.

(90, p. 486)

With regard to clarifying responsibility to the client as an individual whose integrity must be highly valued, Bixler and Seeman point out that the problem has been complicated by the fact that consulting psychology

---

\* Hand, H.C. America must have genuinely democratic high schools. General Education In The American High Schools (Chapter 1, pp. 3-40). Chicago: Scott Foresman, 1942.

has developed primarily in institutions and agencies so that a third party, so to speak, has been involved in the client-consultant relationship. The psychologist, in such a situation, is responsible to the administrative agency and also to the client. This may lead to much ethical confusion since the administrative responsibility is primarily to the group rather than to the individual. The problem is illustrated in relation to the issue of the free-flow of confidential reports about an individual within an administrative agency which seems necessary from the point of view of the agency but which may violate the client-consultant relationship. Bixler and Seeman seek the answer to these problems in terms of the chief duties of the psychologist, namely, diagnosis and therapy.

In the matter of diagnosis, it is essential to clarify wherein the ethical responsibilities lie and this may be done in terms of whether the client voluntarily seeks diagnosis or whether the diagnosis is requested by some agency. Where the client voluntarily initiates the diagnosis all data and information must be kept strictly confidential unless the client grants permission to do otherwise. Where the diagnosis is requested by an agency reports may be transmitted provided the client is fully aware of the situation. In these situations the psychologist's duties may often be quasi-administrative

and this should be differentiated from the more clearly therapeutic duties.

In the matter of therapy strict confidence must be the rule on all occasions regardless of whether the client comes on his own initiative or not. Bixler and Seeman state:

Under all conditions treatment is a private matter between the psychologist and the client, and it should be the duty of the psychologist to hold in confidence all information elicited in the treatment interviews. Sometimes it happens that in practice diagnosis and treatment are closely intermingled; in such cases it should be the duty of the psychologist to exercise utmost discretion in deciding what information may be legitimately reported and what information should be withheld. When treatment is the predominant goal of the contacts, confidence should be kept at all times.  
(90, p. 488)

The above rule should be modified somewhat to take account of those cases where the patient is mentally disturbed to the extent of being incapable of assuming responsibility and of fully comprehending the significance of a therapeutic situation. Also, diagnosis and therapy are almost always intermingled rather than only occasionally as Bixler and Seeman state so that the ethical problems are more complex than they indicate.

In regard to clarifying responsibility toward related professions, Bixler and Seeman suggest the principle that such responsibility must be determined



within the framework of the responsibilities of the client-consultant relationship already discussed. The consultant psychologist has two primary responsibilities which may be carried out in this framework, namely, to make his technical skills available to other professional workers, and to educate them concerning the meaning and significance of these technical skills.

The consultant psychologist's responsibility toward society is in large measure met by fulfilling his responsibilities toward the client, for a well adjusted individual will ultimately contribute to the betterment of society. There are, however, responsibilities outside of the client-consultant relationship. It is considered mandatory that the psychologist assume obligations in the area of prevention and mental hygiene--he must prevent maladjustment as well as treat it. This includes or implies duties in the area of lay education relative to the principles of mental hygiene. The psychologist is also obligated to serve all people regardless of ability to pay or their religious, racial or educational affiliations. In brief, Bixler and Seeman stress that the creation of a code of ethics is a social as well as a professional act. They state:

A professional group whose code is attuned to its needs alone and which remains insensitive to social requirements finds itself falling behind the development of society and maintaining

the status quo. If a code of ethics is to remain a positive professional force, it must use as a continuous frame of reference our one purpose for existence: service to the individual and to society.

(90, p 490)

W. H. D. Vernon's (91) attack on the professional problems of the consulting psychologist is somewhat different from those reported above in that he attempts to form an empirical groundwork for their solution following a rationale similar to the L. J. Elliott (86) study in social work (though Vernon does not refer to Elliott). Vernon notes that the variety of problems in the area of professional ethics which face the consulting psychologist today cannot be solved by easy reference to established practice as in the case of the older professions like medicine. It is valuable, even necessary, to sample the attitudes and opinions of consultants in the field and Vernon uses the questionnaire method as an initial way of accomplishing this end. The questionnaire included questions concerning advertising, fees, relationships with the medical profession, and other professional problems. It was sent to a small sample of consultants but a wide geographic area was tapped as well as a wide variety of clinical situations. An attempt was made to contact the experienced consultants in the hope that their experience might provide the basis for further study. The main outcome of the findings is that all of the psychologists who

responded to the questionnaire agree on the urgency of the professional problems and that only a beginning has been made toward their solution.

#### 4. Suggestions on the Problem of Standards of Professional Achievement and Competence

One of the essential meanings of the concept of profession, is that it requires that standards of achievement and competence be maintained with respect to carrying out the functions, responsibilities and duties of the profession. In clinical psychology, however, much of the present interest and concern must be with the initial problems of setting up and obtaining reasonable agreement upon standards. These problems are complicated by the uncertain and unsettled status of clinical psychology as discussed in Chapter I. Further the whole problem of setting up standards and of obtaining agreement on them depends directly for its solution upon the solution of problems related to the definition of clinical psychology. This last has been the major concern of the present thesis so that some suggestions regarding the problem of standards may be expected as a possible outcome.

The suggestions offered here will be limited to the difficulty that is expressed in the rather confusing variety of titles under which clinical functions are carried

on today. There are, for example, such titles as psychometrist, consulting psychologist, personnel consultant, counselor, personnel technician, psychological examiner, clinical psychologist, or simply, psychologist. The selection and use of these titles does not appear to be a mere matter of words, or personal taste. It seems, rather to be a definite reflection of incomplete and unsystematic ideas, or merely presumed and implicit notions of what types of functions and duties the professional worker in psychology should perform. The selection may be partly a reflection of the area of clinical practice and the circumstances under which the clinician functions, but this seems to represent only a superficial or possibly an indirect factor which even when significant is rarely recognized clearly as such. In general, the selection and use of titles to describe professional psychological functions tends to be made on an arbitrary basis in that it is not guided by a clear idea of the nature of clinical psychology.

K. F. Heiser (92) comments on this situation regarding the confusion of job-titles and the consequences of such confusion from the standpoint of the ethics of the profession. He writes:

Until the profession has come to general agreement on the standards and classification of psychological services, such titles and positions as psychometrist, psychological examiner, and assistant

psychologist should be discouraged and that college departments should cease advising their young graduates that they may go into the interesting field of mental testing with the B.A. degree or less. It is neither good science nor good professional practice for such persons, in the name of psychology, to report test results to employers, parents, etc., who are seldom able to make proper use of them. Psychologists are not to be blamed for the over expansion, commercialization and weakness of the mental testing movement, yet they should not have been so ready to use it as a means of placement of thousands of young majors who are eager to be of social service in this limited vocational field. (92, footnote p. 626)

Suggestions as to how this unfortunate situation may be remedied and as to how much of the activity done at a mental testing level may be made professionally valid (rather than as Heiser seems to suggest that it be discouraged entirely) will be made below.

The major contention being advanced here is that there is no generally recognized and accepted generic concept of clinical psychology considered in all its aspects as a science (in both a pure and an applied sense), an art and a profession. Consequently, there is a great deal of confusion and misunderstanding regarding proper functions and duties, and the confusion in the selection and use of titles is symptomatic of this more basic confusion. Functions, responsibilities and duties are defined without reference to a generic discipline the existence of which is not widely enough recognized. This whole situation

may be illustrated by the data presented in a recent article on occupations in psychology by C. L. Shartle (93). The article presents job classifications and descriptions of positions in psychology based upon material gathered from a questionnaire study in which psychologists employed in various situations and positions (limited largely to federal and state civil service agencies) participated. Twenty-eight descriptions are presented and included under each is a statement as to duties performed and qualifications necessary in the position. Several interesting observations may be made about this material to illustrate the point under discussion. Of the twenty-eight positions described, the following make use of some aspect of clinical psychology considered as a generic discipline;

- 2.\* Counselor, College (Social Adviser, Director of Vocational Guidance, Junior Dean)
4. Psychologist, Public Schools (Psychoeducational Examiner, Public School Psychological Examiner, School Psychologist)
5. Psychologist, Clinical, General (Clinical Psychologist, Clinic Teacher)
6. Psychologist, Child Guidance Clinic (Child Guidance Psychologist, Psychoeducational Examiner, Supervising Psychologist, Child Psychologist, Junior Psychologist)
7. Psychologist, Feeble minded Institution (Supervising Psychologist, Clinical Psychologist)
8. Psychologist, Hospital for Insane

---

\* The numbers are those used in the article from which the descriptions are taken.



9. Psychologist-Juvenile Correctional Institutions (Clinical Psychologist, Juvenile Correctional Institution)
10. Psychologist, Penal Institution (Prison Psychologist)
11. Court Psychologist (Clinical Psychologist)
13. Psychologist, Hospital (General and Neurological, Psychological Intern, Clinical Psychologist)
14. Psychologist, State Civil Service, General (Clinical Psychologist, Supervising Psychologist)
17. Psychologist for Physically Handicapped (Rehabilitation Training Officer, Vocational Psychologist for Handicapped)
21. Consulting Psychologist (Personnel Psychologist, Clinical Psychologist, Educational Psychologist, Industrial Psychologist, Personnel Consultant)
22. Psychometrist
27. Vocational Adviser, Veterans Administration
28. Vocational Counselor, Community Agency

Several other positions among the twenty-eight also require the use of aspects of clinical psychology in a more or less indirect or implicit manner, but they are not listed here.

It is interesting to note that positions five through fourteen (5-14) are actually classified under the general title of clinical psychology as involving duties and functions which imply a generic discipline of clinical psychology. This may be interpreted as corroboration of the viewpoint being advanced here, but it may well be asked why the several other positions which require the practice of clinical psychology to an equal extent are excluded or not clearly included under the general title of clinical psychology. The answer is provided by the

writer of the article, who makes it plain that the job-titles and corresponding duties are those actually found in the field rather than what they should be in terms of professional standards. It should prove valuable to rework the information provided by Shartel (along with any additional data that could be gathered in a similar fashion) with the objective of setting up professional standards. To accomplish this end it would be necessary to start out with a clear concept of clinical psychology as a generic discipline. It should then be possible to select titles in accordance with clearly defined functions and duties which may be distinguished in terms of levels of achievement and competence. Sub-titles referring to the area or situation could be added on a clearly designated basis and the description of the duties could be modified explicitly in accord with the particular area and situation. Thus the title, clinical psychologist, may be reserved to signify thorough achievement and competence in all basic aspects of clinical psychology as a generic discipline including the principles of psychometrics, diagnosis, therapy and all modified or minor forms of therapy such as counseling and interviewing which require an expert and professional manner of dealing with individuals. The term intern or extern would be employed to designate only partial fulfillment of the above standard. Terms like psychometrist would imply achievement in only one technical aspect of

clinical psychology. This whole plan should help to clarify the problem of training, and to clarify the status of clinical psychology as a profession with respect to its proper functions, duties and responsibilities.

### 5. Problems of Training

To attain professional standards it is obviously necessary to institute some sort of program of training. The program of training should serve to implement the standards which are to be maintained and will clearly bear a direct relationship to the kind of standards which are set up. Proposals for training become intelligible only in reference to a specific set of standards and thus cannot be accepted or rejected outside of such a framework. Though this fact appears obvious enough its importance from the viewpoint of maintaining perspective and orientation with regard to specific training proposals cannot be overestimated.

There is a recent but rapidly growing literature on training problems, as is true for most of the topics under discussion in this chapter. This may be taken as evidence that problems relative to the clarification of the professional status of clinical psychology are now being recognized as vital to the development and improvement of clinical practice. In the case of training, there is evidence not only of recognition of the urgency of the

problem but also of comparatively good progress toward its solution. There seems to be fairly good agreement that a well organized training program is necessary, and that training for clinical psychology involves certain essential general requirements. Examination of reports of Committees of the American Psychological Association and of the American Association for Applied Psychology (94 and 95) reveals apparent agreement on the following main general requirements for training in clinical psychology on a doctorate level:<sup>\*</sup> (1) Basic academic course work should include grounding in the fields of psychology as well as in allied social sciences. The emphasis is upon providing the broadest possible foundation not only in the biological sciences and in psychology, but in the social sciences related to clinical psychology. (2) Training in various specific clinical methods including psychometrics, case-study, interviewing and therapy is regarded as essential. The use of practicums in actual clinical settings seems to be recognized as invaluable if not indispensable as a training procedure in connection with acquiring skill in the use of the above mentioned clinical methods and

---

\* The general term doctorate is used because there have been suggestions by A. T. Poffenberger (96) and others that a doctorate other than a Ph.D. be given. This is intended to distinguish the clinician from the academic psychologist.

techniques. (3) An entire year of the training program should consist of a full-time internship at an appropriate institution. W. R. Morrow (97) reviews the whole history of internship as a background for comprehending the present general acceptance of internship as a necessary and integral part of training. He cites the report of the Subcommittee on Graduate Internship Training of the American Psychological Association (95) as an expression of this general acceptance. His summary statement of the Subcommittee's work is quoted here:

The proposals of the Joint Subcommittee constitute by far the most comprehensive treatment of the internship problem yet offered. Internship is solidly embedded in a broad, integrated course of preparation for clinical psychology. Three main levels of professional operation are distinguished: senior, junior, and postgraduate. Main consideration is given to the first, which is viewed as requiring a four year graduate training period (one year of which is to consist of an internship) and leading to a doctorate. A tentative outline of the recommended academic content is given. The conditions and content of the internship are then discussed in detail. It is recommended that internship should embrace experience with various diagnostic procedures including history-taking, interviews, and clinical psychometrics: some psychotherapy; attendance at various departmental and institutional staff meetings and seminars; a research project; some administrative experience, including certain departmental office duties as well as experience in the supervision of other interns. . . . (97, p. 176)

(4) There seems to be full agreement that training in

research should be a part of the required training program.

These training requirements in broad outline seem to be consistent with a concept of clinical psychology as a generic discipline. D. Shakow (98), who served as chairman of the Subcommittee mentioned above, also proceeds on this basis in a recent article on training. He points out that clinical psychology may be considered as forming the groundwork of all professional psychology that is primarily concerned with the individual in a therapeutic way. He admits, however, a bias toward psychopathology and this, it seems, tends to negate somewhat a generic concept. It is not difficult to compensate for this weakness in Shakow's plan because it appears basically adequate and well formulated to allow for modification. The goal of training which he sets up is to produce a psychologist of professional stature rather than to produce a mere technician; a clinical psychologist rather than a psychometrist. An ideal psychologist is one who "besides meeting certain basic personality requirements and having a breadth of educational background, is competent to carry a triad of responsibilities: diagnosis, research and therapy (98, p. 278." Shakow outlines a four year program for graduate training which is in keeping with the requirements mentioned above except that there is a definite emphasis on the psychopathological and on the medical in the basic courses to be included.



Some suggestions might be offered by way of modifying Shakow's plan to make it more consistent with a generic view of clinical psychology which does not delimit its functions to those associated with the psychopathological or the strictly medical. The first two years of Shakow's plan which are intended to provide a basic groundwork need not be altered, but the last two years which include the internship and the research may be formulated in flexible terms to provide for specialization in a particular area of application. For instance, if the clinical psychologist candidate were preparing for a career in the guidance of college students, his internship and research could be accomplished at a guidance bureau in a college. If the candidate were preparing for a career in counseling in an industrial setting, his last two years might well be spent in an industrial plant. In short, for a candidate preparing for a career in a mental hospital, Shakow's plan is excellent as it stands, but in any other case it is not flexible enough to meet the demands of preparing clinical psychologists to function in varied types of special situations, and the last two years should be modified accordingly. A minimum amount of training in medical and psychopathological materials should be guaranteed to meet the legitimate claim that clinical work should be firmly grounded in a knowledge of psychopathology, and to meet the requisite of acquiring

therapeutic intent in G. Zilboorg's terms.\* Beyond this, however, specialization should be provided for to meet the needs in the special areas of application.

These suggestions are made in accordance with the notion that there are undeniably different areas of special application such as in educational institutions, health and welfare institutions, and in business or industrial institutions which present their own special types of problems and require special training for effective handling of these problems. Nevertheless, these different areas of special application are clearly recognized as areas of special application in the strict sense. They are areas of special application of a generic discipline and thus have a great deal in common as to principles and methods employed within them and therefore as to basic training requirements for effective functioning within them. In brief, training must be of both a basic and specialized nature to provide for both what is common and not common to the various areas of application.

Any discussion of training for clinical psychology would be incomplete without some mention of the problems which arise in connection with the fact that certain very definite personal requirements for clinical

---

\* See page 22 for Zilboorg's concept of therapeutic intent.

practice cannot be easily satisfied by a formal training program of any sort. These personal requirements are directly associated with the requirements of clinical practice from the standpoint of the ethics of the profession. If the ethics of clinical practice means anything, it means that the clinician must be primarily interested in the welfare of individuals within the limits of the welfare of society. This means the clinician must have the ability to make warm human contacts. G. R. Rogers (99) stresses this point and adds that the clinician must have an interest in people as individuals together with a deep desire to be of help to them when such help is required. D. Fryer (100) speaks of the vital necessity of maintaining an attitude of personal worth toward the client.

The fact that adequate help to an individual can be given only within the framework of a clinical relationship gives rise to additional personal requirements. The clinician must be emotionally mature in that he must be fully aware of his own role in the clinical relationship and has reasonably good control over his own emotional investment in the situation to the extent of preventing that investment from interfering with the course of therapy. The psychoanalysts demand that the therapist be psychoanalyzed--the didactic analysis, so-called--by way of satisfying this requirement. Others, like C. R. Rogers (99), merely demand that some method, not necessarily psycho-

analysis, of obtaining knowledge of the self and of attaining emotional maturity be employed. B. C. Reynolds (101), a social case worker, aptly refers to the personal requirement under discussion as the need for a "professional self" which arises out of the very definition of case work in terms of the use of relationships to solve problems of life adjustment.\* The professional self consists of a professional consciousness or self-awareness and is regarded as, "the very dynamic core, the differentiating characteristic of social case work (101, p. 61)." With regard to the necessity of training a professional person in self-awareness, Reynolds states:

.... It seems that he (the professional person) must if he is to be accountable for his own part in helping to bring about better adjustments of other people--that is, if his profession is social work. He must be in the situation, it is true, but above it enough to use foresight in gauging the probable outcome of what he does. He must watch what he is doing enough to be able to change if something is wrong. He must have some notion of how his own feelings are complicating the situation, and be able to make allowance for them (101, p. 63).

The personal requirements, or better, the personality and character attributes, which are essential for clinical practice from the standpoint of the ethics of the profession may be viewed in terms of A. H. Maslow's (102) analysis of authoritarian versus democratic character

---

\* Social case work and clinical psychology are essentially similar in respect to the points under discussion so what is stated regarding one holds equally well for the other.

structure. Maslow, to a certain extent following Erich Fromm, points out that the authoritarian proceeds on the assumption of living in a hostile world of "dog eat dog", consequently the authoritarian measures people in terms of their power to harm him or their ability to protect themselves from harm that he might inflict upon them. The authoritarian in accordance with his essential character must regard people as more or less inhuman in the sense that he has no respect for each individual's set of personal values, accomplishments and personality. He views people in terms only of his own set of values which are based on fear and need for power. He can trust nobody because all are potentially threatening while the democratic person trusts or mistrusts people on the functional basis of understanding them. The authoritarian has no appreciation for individual differences among people because for him all people are either superior or inferior to him with respect to one criterion--power.

It is clear that the clinician must be a democratic person in Maslow's sense because, (1) he must recognize individual differences in all aspects of personality, personal values, and achievements; he must be able to evaluate and accept them from the standpoint of the individual, (2) he must be able and willing to allow an individual to grow, change and develop on the individual's own terms (within the limits of the social welfare), rather

than on the clinician's terms which may be arbitrarily imposed and primarily reflect the personal needs of the clinician above the welfare of the client, (3) he must, in ordinary language, be unselfish, kind, sympathetic and human. The authoritarian cannot be kind because kindness is weakness on the basis of his assumption of an entirely hostile world.

#### 6. The Issue of Certification and Licensing

Certification and/or licensing is an expression of the achievement of professional status. It thus implies at least a temporary solution of most of the problems and issues involved in understanding and defining clinical psychology as a profession.\* Many of these problems and issues are not only controversial but have not yet received clear formulation with respect to their interrelationships and their implications so that their full significance cannot be generally appreciated. It would not be surprising to find that there is a great deal of confusion on the issue of certification especially since the immediate relevancy of the problems and issues involved in the ethics

---

\* Certification is distinguished from licensing in terms of legal strength or power, the former being the weaker form of legislation. Certification grants permission to practice, while licensing also prohibits practice.



of clinical psychology is likely to be overlooked.\* Nevertheless, certain leading psychologists have clearly recognized the need for certification and have been very actively engaged in the almost insurmountable task of building the foundations of a national program. The American Psychological Association in its September, 1946, annual meeting received a report by a Committee appointed to plan a certification program which contains proposed by-laws for the certification of professional psychologists (103). These by-laws provide for the creation of an American Board of Examiners in Professional Psychology which would be more or less comparable to the Board of Examiners in Psychiatry that functions in the certification of psychiatrists. The by-laws provide for certification in "three general fields," clinical psychology, industrial psychology, and guidance. The interesting thing to be observed from the standpoint of the present study is that the Committee was apparently unable to arrive at a satisfactory basis for clearly differentiating these three fields and recommended that the task of doing so be left to the Board. Thus, the committee states:

---

\* A recent panel discussion which took place in the Psychology Section of the Kansas Academy of Science, April, 1947, revealed an appalling amount of confusion on the subject of certification. This is not cited with any criticism of that group because it is felt that the same situation would exist among any group of psychologists today, and also the panel was intended to bring forth the controversial issues.

The precise definition and demarcation of these fields and the setting of appropriate standards have been left to the Board's wisdom and experience.

(103, p. 512)

The by-laws, in other words, do not contain any statement as to the exact nature of these fields of professional activity and no statement of their similarities and differences. The reason for this state of affairs is that universal agreement on the part of competent observers has never been obtained, and it is to be noted that other Committees of the American Psychological Association are working at the task of obtaining the basis for such agreement. Until this is accomplished, certification can have very little actual meaning in the sense in which it is understood in this study.

Another significant omission from the proposed certification program is that it is set up without the guide of a specific code of ethics. The only mention of ethics is in the section of the by-laws dealing with qualifications where "satisfactory moral and ethical standing in the profession" is stated as a general qualification for certification. The difficulties in formulating a code of ethics are fully recognized and the fact that professional psychology is not quite ready for a specific code is admitted, but it must nevertheless be realized that effective certification must be based on such a code.

Several State certification programs have been put into effect within the past few years. K. F. Heiser (92) reports the experiences of psychologists in Connecticut in formulating and passing state legislation. The Connecticut program is open to the same basic objections indicated in connection with the national program of the A.P.A. For example, the certification law is set up independently of the certification program pertaining to school psychologists which in Connecticut is under the jurisdiction of the Commissioner of Education. Heiser deplores this isolationist arrangement but reports the feeling that independent standards should be set up. From the viewpoint of the present study, however, complete unification of standards is highly desirable though specific provisions may be made for specialized areas. Thus, a school psychologist may be defined in terms of the same general standards as a clinical psychologist but specifications may be made to take account of the fact that the work is with children in an educational setting.

In concluding this chapter, it may be stated that if the services of clinical psychology are to be of maximum benefit to the welfare of the individual and to society, they must be performed on a professional level. If they are to be performed on a professional level, they must be conceived within the framework of the principles of ethics, particularly the principles of the ethics of

professions. This requires that the services be considered in terms of basic values, specific aims and objectives, standards of achievement, and standards of training. It presupposes an understanding of the nature of the services with respect to the theories, methods, and techniques that are used in carrying them out. A code of ethics and a certification or licensing law can then be built as a formal expression of all these considerations and requirements and as an assurance that the services offered by clinical psychology will be performed on a professional level.

## Chapter V

### SOME PROBLEMS IN PSYCHOTHERAPY AND PSYCHIATRY AS RELATED TO CLINICAL PSYCHOLOGY

#### 1. General Plan of Chapter

Psychotherapy is a significant aspect of clinical psychology even though there is still disagreement from various sources and for a variety of reasons as to its exact nature and as to the extent of its significance. One important group of clinicians, however, regard psychotherapy as an extremely significant aspect of clinical psychology and, in fact, almost reach the point of regarding psychotherapy as the most significant aspect of clinical psychology. This group (from all appearances a large and growing one) is led by C. R. Rogers, who makes this statement in the preface of his recent book on psychotherapy:

In the period of the 1920's the interest in the adjustment of the individual was primarily analytical and diagnostic. In social work it was the period of the flowering of the case history; in psychology there was a lush tropical growth of tests; in educational guidance both records and tests grew apace; in psychiatry multi-syllabled diagnostic labels blossomed into elaborate diagnostic formulations. Never had so much been known about the individual. As time has gone on, however, these groups, and others with similar interests, have given more consideration to the dynamic processes through which adjustment is improved. The balance has definitely shifted from diagnosis to

therapy, from understanding the individual to an interest in the processes through which he may find help. Today the professional worker who is concerned with the adjustment of the individual wants to know how he may become more effective in therapeutic ways in assisting the individual to readjust. (46, p. vii)

If it be granted that psychotherapy is a significant part of clinical psychology, it becomes imperative to understand the meaning of psychotherapy and to know the principles and techniques upon which it is based, to say nothing of the need to acquire the skills required for its successful application. This will probably be readily admitted, but agreement on the meaning of therapy and upon its general principles and techniques is yet to be obtained. The present situation is characterized by the existence of a great many opposing schools of therapy and this fact presents tremendous difficulties which impede the task of organizing clinical psychology as a systematic discipline. It should be recognized that the present situation is undoubtedly an inevitable stage in the growth of knowledge and that it is also a reflection of the immense complexity of the subject matter. Perhaps its immense complexity will never allow any thoroughgoing organization of therapy. Nevertheless, it should prove profitable to examine the various approaches to therapy for the purpose of discovering its most basic meaning and its fundamental principles.



Such a comprehensive examination will not be attempted here. The present purposes are: (1) to sketch briefly the present character of psychiatry in order to widen the basis for understanding psychotherapy, (2) to indicate some of the various schools of psychotherapy and to offer some evaluation of their significance, (3) to discuss some of the problems and issues involved in the choice of some of the opposing schools over others, (4) to arrive at a brief statement of the scope and tentative meaning of psychotherapy which could be used to clarify its role in clinical psychology.

## 2. Brief Sketch of Present Character of Psychiatry

Psychiatry is a specialized branch of medicine. As a profession it is practiced only by physicians, but as a discipline its subject matter is not exclusively a part of medicine unless medicine be defined in extremely broad terms. In earlier times the subject matter was more easily recognizable as part of medicine though ironically psychiatry has always been a step-child of medicine and even today is not fully accepted, if one measures acceptance by the number of medical schools which offer full training in psychiatry.\*

---

\* Eugene Meyer, President, National Committee for Mental Hygiene, recently stated in this connection: "I think as far as I know, there is only one medical school in the United States, up to recently at least, where they have had psychiatry as part of the regular medical course from the beginning to the end of their course."

The part of psychiatry which is definitely a branch of medicine (in the conventional sense) is that which is exclusively concerned with mental illness in its most severe forms. The organic mental diseases obviously fall in this category, but the so-called functional diseases, mainly the functional psychoses and severe neuroses which have distinctly somatic involvements also must be so classified.

The modern concept of the scope of psychiatry, however, does not limit its role to the diagnosis and treatment of severe illness, nor even of mild illness. It is concerned also with the personality and behavior adjustment of relatively healthy and intact individuals. Even though the psychosomatic character of all behavior be fully recognized, and it be recognized that psychiatry as a branch of medicine should therefore be properly concerned with all behavior, the fact remains that psychosomatics goes far beyond medicine. Indeed, it goes so far beyond the ordinary confines of medicine that it includes aspects of the subject of all the social sciences as well as philosophy. This is seen in a recent statement of B. Glueck (104) in which he refers to psychiatry as "an instrument of personal and social rehabilitation" and as a science of human relations which has a significant contribution to make toward the solution of the major social problems of our times. He writes:

. . . In times like these one recalls that the achievement of harmony out of chaos and conflict and the searching out and mastering of the conditions requisite for a competent and satisfying personal and social adjustment are among the chief preoccupations of clinical psychiatry. Unlike other medical specialties which measure their achievements largely in terms of morbidity and mortality rates, our speciality (psychiatry) stresses more particularly the quality, the worth, the meaning of human existence. It conceives its task in terms of total situations, and concerns itself not only with the personal make-up and reaction tendencies of the individual but also with the milieu in which he has his being, the particular setting in which he is obliged to live out his destiny. . .

Naturally, it is not contended here that psychiatry has the answer to all the problems which confront our postwar period. But it is a fact, nevertheless, that the psychiatrist, more than any other specialist in our society, is called upon to deal with the crises in human relations. . . . (104, p. 15)

This same impression of the breadth of psychiatry is given in the definition offered by J. H. Masserman in his recent book. He defines psychiatry as the "science of human behavior--its determining factors, the techniques of its analysis, its vicissitudes and aberrations, and the methods that may be employed to align behavior with desired social norms." (105, p. 3) The implications of this definition are extremely wide, for, an individual's conduct is dependent on biological factors and his behavior is interwoven with the cultural milieu so that psychiatry draws on ancillary disciplines. Masserman,

however, does not take account of the further important implication that if psychiatry is to be concerned with aligning behavior with desired social norms it must also have ethics as an ancillary discipline.

A. Gregg (106) has recently emphasized a similar view of psychiatry as being defined not simply as a medical specialty but as dealing with all aspects of emotional, mental, and social life. He writes:

the province of psychiatry is the disturbances in the conduct of man, his experiences and his ways of experiencing, his reactions, his behavior as an indivisible sentient being with other human beings.  
(106, p. 138)

He states further that psychiatry:

spreads into the anxieties, the fatigues, the instabilities, the maladjustments, the disturbances of normal everyday living--and includes--the effects of mental and emotional functions upon component organs of the body as well as effects of disordered organs upon the function of the human being as a whole. (106, p. 138)

It is interesting to note that Gregg admits:

the psychiatrist's domain is almost bafflingly large, for it includes derangements of conduct and behavior often discernable only in terms of the patient's relationships with other human beings in some given intellectual or cultural or social or moral system. (106, p. 139)

An outstanding fact about the history of psychiatry in the last hundred years, then, is that it has widened its scope from a concern with mental illness to a far-reaching

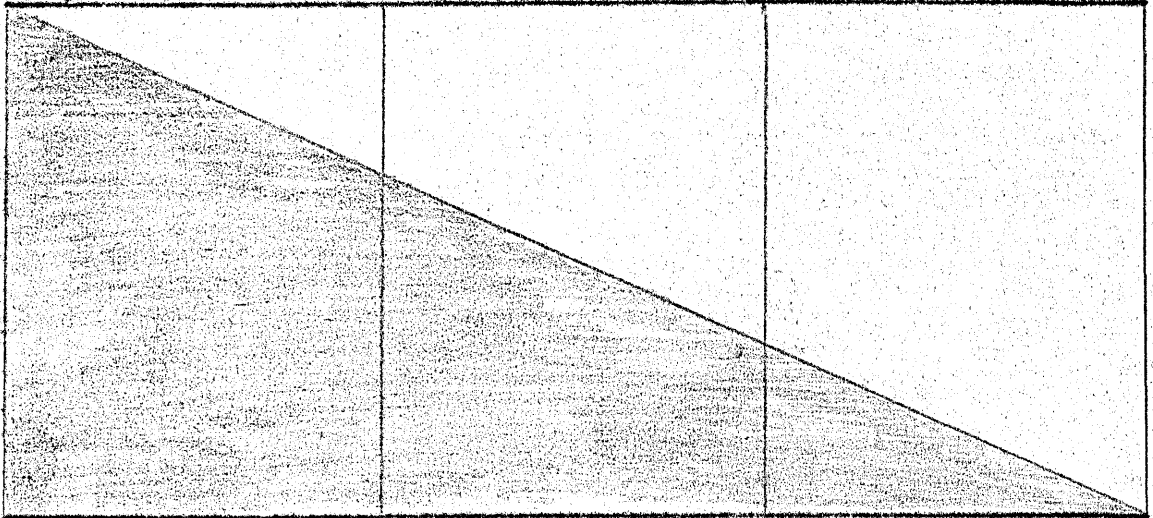
interest in human personality and human affairs. This is of tremendous significance for clinical psychology, for the following reasons: (1) the content of psychiatry overlaps to a considerable degree the content of clinical psychology, (2) the problem of the boundary lines between the two disciplines is probably insoluble as far as subject matter is concerned though certain conventionally medical aspects of psychiatry clearly are outside the range of clinical psychology, (3) as far as psychotherapy is concerned, clinical psychology must adopt a good many of the theories, methods, and techniques that are formally psychiatric in the sense that they are propounded by psychiatrists.

The following diagram taken from a recent book by P. Alexander and T. M. French (107, p. 9) may be used to illustrate the particular types of mental illness which may be included within the range of psychotherapy that can be considered part of clinical psychology.

Group I (Severe  
and Chronic with  
Psychotic  
Symptoms)

Group II (Severe  
and Chronic  
Psychoneurotic)

Group III (Mild  
and recent  
Neurosis)



(Shaded area represents unfavorable constitutional factors plus traumatic experiences in infancy and childhood. Blank area represents traumatic experiences in later life)

The particular purpose of the authors of this diagram will be indicated later, but the present purpose is to show that the illnesses in Group I (includes the chronic cases with psychotic symptoms), and those in Group II (includes all of the cases of severe psychoneuroses some of which have overt psychosomatic symptoms) are definitely excluded from clinical psychology as far as responsibility for treatment is concerned. The illnesses in Group III may be described as temporary maladjustments or neurotic breakdowns in that they are the result of recent or current traumatic experiences in basically well adjusted persons. Since the symptomatology in this group may resemble that



of Group II, and since psychosomatic involvement be present here also, clinical psychology cannot assume full responsibility for treatment, but must always function in conjunction with psychiatry. In those types of cases which are clearly mild maladjustments and present no obvious psychosomatic symptomatology clinical psychology may be practiced more autonomously, though never completely, for the etiology of psychosomatic symptoms is rarely obvious.

As already indicated, the theories and methods of psychotherapy have their origins largely in psychiatry. Though a complete understanding of psychotherapy requires that all of the schools of psychiatry be critically explored, only one such school will be briefly evaluated here. Since it has probably exerted the most influence over the development of psychotherapy and yet has stimulated the greatest amount of controversy, the psychoanalytic school is chosen.

### 3. The Psychoanalytic School of Psychotherapy

Several distinctions concerning the meaning of the term psychoanalysis must be made at the outset to avoid confusion. J. F. Brown (108) points out that it has at least three meanings:

It is, in the first place, a technique which investigates the dynamics of the unconscious and conscious mental life of the individual. By dynamics in this sense we mean the distribution and change of psychic forces. Through an investigation of the

mental life of the individual it is often possible to manipulate the psychic forces so that a restructurization of the personality ensues. So psychoanalysis is, secondly a form of psychotherapy which attempts to restructure the neurotic or psychotic or perverse or psychopathic character . . . . From the use of the technique of psychoanalysis as a therapy has grown a series of important and systematized theoretical constructions. Psychoanalysis is thus, in the third place, a system or school of psychology . . . . (108, p. 155)

Roland Dalbiez (109), a French scholar, bases his exposition of the work of Freud on what he regards as a fundamental distinction between Freud's method and doctrine. This distinction is the "leitmotif" of Dalbiez's approach to Freud in that he attempts to separate out from what is commonly and grossly known as psychoanalysis that which is scientific method (defined as depending only on a doctrine of realism, a metaphysics Dalbiez regards as central for all science) and that which is doctrine and theory in the sense of being dependent upon further scientific proof and logical demonstration for its acceptance. What Dalbiez regards as Freud's scientific method is the same as what J. F. Brown refers to above as the technique of psychoanalysis. This is clear from his following comments made in connection with Freud's work on dreams;

We therefore receive his (Freud's) theory of dreams as a synthesis on a methodological base. In this complicated

structure it is important carefully to separate the theory properly so-called from the method which has permitted its construction. Too often, especially in France, the two points of view have not been distinguished. This confusion is similar to that which would arise from identifying the cellular theory of biology with the discovery of the microscope. The invention of new methods of research is a definite gain to science. The telescope and the microscope endure, while astronomical theories succeed one another and so do histological ones. The word "Psychoanalysis" is unhappily accepted in a double sense, being used both for the method and the doctrine. It would be convenient to keep the term psychoanalysis, as Pichon has proposed, for the method, and to call the body of doctrine Freudism. But it is doubtful whether this precision of language would succeed in holding its ground . . . (109, p. 39)

G. Landis (110) differentiates psychoanalysis in terms of its being a therapy, a theoretical system, and a method and maintains that the latter is "a relatively definable, repeatable, partially controlled psychological experiment during which a scientific method of sorts is followed." (110, p. 516) This is essentially the same as Dalbiez's notion, and Landis like Dalbiez points out that the method may be accepted independently of the specific theories of Freud.

F. Alexander and T. M. French (107) make similar distinctions when they state psychoanalysis is;

(1) a psychodynamic theory of the development of the personality, (2) a method of investigation, and (3) a therapeutic procedure. (107, p. vi)

For Freud, then, psychoanalysis was at once a method or technique which was simultaneously employed as a therapy and as a research method of discovering, advancing, and as far as possible of proving theories of personality structure and functioning. Psychoanalysis today still represents all of these phases but they may be practiced independently with respect to whether the primary purpose is therapy or research.

Concerning the question of whether the method or technique is scientific, it should be pointed out that this can only be decided in terms of whether science is defined rigidly or broadly, a question which was discussed in chapters II and III of the present study. Dalbiez raises the question in connection with the issue of the scientific versus the historical character of psychoanalytic psychology of the neuroses and shows that this psychology can never be thoroughly scientific because it must deal with the individual psychic history that can be only understood in terms of its own individuality rather than in terms of a universal law. Dalbiez regards this issue as fundamental and as having constituted a stumbling block to the understanding of psychoanalysis. He writes:

Analysis explains the individual present by the individual past. If we adhere to the narrow meaning of the word "science," which limits this term to the explanation of the particular by the general, of the event by the law, in contradistinction to history, which is the explanation of the event by an

antecedent event, we shall say that psychoanalysis is a discipline, not of the scientific but of the historical type. If we adopt this terminological convention, we must recognize that many sciences contain an important and irreducible historical element. Let us consider in geology, for example, the problem of the structure of the Alps. Since the Alpine Massif is, in the philosophical meaning of the word, an individual, the explanation of what is unique in its formation will be a question for history, not for science to determine. If, on the contrary, we accept a wider definition, regarding as scientific every correct demonstration of a causal relation, even between strictly individual elements, there is no reason why we should refuse to call psychoanalysis a science. Moreover, whereas psycho-analysis begins by relating the individual to the antecedent individual, it is not precluded from subsequently rising to the level of generalization; we need merely to recall the theories of the failed act, of the dream, or of the neurotic symptom, and the speculations on instinct or the structure of the psychic apparatus.

(109, p. 147, V. II)

In so far as the method of psychoanalysis is used as therapy it can not be considered completely scientific. F. Alexander and T. M. French point this out, though in an apologetic way:

It is admitted that psychotherapy is still more an art, requiring a constant intuitive response to the patient, than it is a science. . . . (107, p. iii)

Their primary interest is in research so they also speak of psychoanalysis as a scientific theory and are interested in arriving at generalizations about psycho-

therapy. This is perfectly legitimate, of course, but it constitutes another sense in which the term science can be applied to psychoanalysis and psychotherapy.

Another important distinction to be made regarding psychoanalysis as a psychotherapy is that between the orthodox standard psychoanalysis practiced by Freud and his students, and the various modified, shortened forms practiced by psychoanalytically oriented psychiatrists and therapists. Alexander and French (107) illustrate this distinction with the diagram reproduced on page 219 of this study. Those cases in Group II constitute the scope of standard psychoanalysis. They are the classical neurotics in the Freudian sense of having deep-seated, early traumatic experiences and/or unfavorable constitutional factors as the primary etiological background. Those cases in Group III lend themselves to the modified, briefer forms of psychoanalysis where there are no early traumatic experiences to be uncovered but where the difficulty lies in the current life pattern or in a recent traumatic experience. In these cases there is no need for a long process of therapy conducted along rigidly defined lines in which the free associations of the patient are obtained as the patient lies on the couch; and in which a "transference neurosis" inevitably accompanies the treatment; and the patient undergoes extreme emotional experiences as he is made conscious of hitherto unconscious and often very unpleasant aspects



of his personality. The aim of standard psychoanalysis is to achieve a profound alteration in the basic personality structure, while the briefer form need not have this objective because the basic structure of the type of personality treated does not require change.

The distinction drawn between these two types of psychoanalytic therapy is highly significant for many reasons. It expresses the growth and development of psychoanalytic therapy from the time of Freud when it was applicable to a relatively small group of patients to the present when it is applicable to a wider range of problems. It actually represents a synthesis of many of the divergent tendencies and opposing schools of psychoanalysis that were headed by Freud's former students who like Otto Rank, Alfred Adler, Karen Horney and others broke with him. Alexander and French et al (197) who represent the Chicago Institute for Psychoanalysis (which presumably has followed the direct line of Freud rather than any divergent one) in devoting an entire book based on a long-time research program to unorthodox, modified psychoanalytic therapy, acknowledge the value and validity of many of the divergent views. They are explicit in their acknowledgment to a certain extent, but they regard their work as a development of psychoanalysis rather than as a synthesis of divergent lines which have been already developed by others. From the point of view of gaining an

understanding of the various controversial principles and theories of psychoanalysis, however, it is helpful to regard the work of the Chicago Institute in this light, as a synthesis of many divergent developments.

This synthesis is expressed in a new definition of psychoanalytic therapy as any therapy:

Based on psychodynamic principles which attempts to bring the patient into a more satisfactory adjustment to his environment and to assist the harmonious development of his capacities. . . .  
(107, p. 27)

It is expressed also in the "principle of flexibility" regarding the techniques and procedures used in the conduct of therapy, which provides for "the application of the technique best suited to the nature of the case."

(107, p. 339) The value and validity of therapeutic techniques is measured not in terms of whether it conforms to orthodox ideas but in terms of serving the central aim of therapy which is:

to increase the patient's ability to find gratification for his subjective needs in ways acceptable both to himself and the world he lives in, and thus to free him to develop his capacities.  
(107, p. 26)

The approach of the present study to the task of understanding and evaluating the several divergent schools of psychoanalytic therapy, and to the problem of evaluating the controversial issues which prompted the several schools,

will be from the standpoint of the newly synthesized views of the Chicago Institute. It would require too much space to accomplish this in detail with respect to all the schools so only a few are chosen though it is felt that it would be valuable to approach all the schools in this fashion.

#### 4. Hypnoanalysis and Narcosynthesis

Hypnoanalysis and narcosynthesis are two basically similar psychoanalytic therapies which represent departures from standard practice. They are mentioned first, however, because they are in a sense lesser departures than some of the others. The present discussion is concerned largely with hypnoanalysis rather than narcosynthesis because the latter involves the use of drugs and can therefore be practiced only by medically trained clinicians. Aside from this fact, the psychodynamic principles and the therapeutic methods are essentially the same in both cases.

Hypnoanalysis is a recent development in psychotherapy though it bears a close relationship to traditional psychoanalysis. L. R. Wolberg (111) in a recent book, makes the following important points concerning the nature of hypnoanalysis and its relationship to psychoanalysis:

(1) Hypnoanalysis requires a shorter time than psychoanalysis because it directly attacks defenses and resistances that are set up by the patient in the first uncovering

phases of therapy, and also because it facilitates the second or re-educative phase of therapy through the use of the hypnotic relationship. (2) It is limited by the fact that some people can not be hypnotized adequately and some therapists are temperamentally unsuited to using it. (3) The traditional concept of complete authority and omnipotence of the hypnotist is discarded and replaced by a concept of therapy as a cooperative endeavor and experience wherein activity and responsibility are shared equally by therapist and patient. (4) The transference relationship is made use of extensively in hypnoanalysis as in psychoanalysis. However, the old objection that hypnotism leads to insurmountable transference difficulties because of the dependent relationship of the patient to the therapist is negated, for, according to Wolberg, it has been shown that hypnotism does not necessarily involve a dependent, submissive attitude on the part of the patient. While it may be necessary to foster the traditional dependency attitudes at the start in order to reinforce the therapeutic relationship, more freedom in reasoning, judgment and interpretation may be given the patient as he comes to realize his own individual powers. Indeed, it may be noted that since Wolberg regards the aim of hypnoanalysis as being the dynamic alteration of the personality structure in the direction of growth of character and strengthening of the ego, he must emphasize the development of assertive rather than dependent attitudes.

Wolberg has a good discussion of the special techniques used in hypnoanalysis such as the technique of free-association in regard to its use in and out of hypnosis, the techniques of dream analysis, dream induction, automatic writing, hypnotic drawing, play therapy, dramatics under hypnosis, regression techniques, crystal and mirror gazing, induction of experimental conflict, and methods of recalling buried memories.

The use of these specialized techniques, however, does not constitute the major point of distinction between hypnoanalysis (at least as Wolberg conceives it) and standard psychoanalysis. Even the use of hypnosis is not the major point of distinction because hypnoanalysis is something more than simply a combination of hypnosis with psychoanalysis. It is a therapy which only incidentally is concerned with uncovering the deep layers of personality and thus differs from standard psychoanalysis which despite the good intentions of many analysts is almost entirely concerned with uncovering, and probing rather than building up positive forces in the personality. It is concerned primarily with the present rather than the past and rejects the notion that catharsis is valuable in itself. Wolberg writes:

The concern with the patient's past emphasized by Breuer and Freud marked a tremendous advance in psychiatric thought, but it had certain unfortunate effects upon some of their contemporaries. It started a trend that minimized the

influence of the actual life situation. In the effort to discover the traumatic roots of the individual's disorder, as well as the infantile patterns that were the prototypes of the neurotic structure, the immediate interpersonal reactions were relegated to a secondary position. The patient often recovered many interesting and crucial experiences, but to the dismay of the analyst, he continued to cling to his neurotic attitudes to life.

It must always be remembered that a neurosis is not a fortuitous happening dependent exclusively upon early traumatic events. It is rather a form of adaptation to and defense against a world that is regarded by the child and later by the adult as potentially hostile and menacing. Current reaction patterns and attitudes, while derived from past experiences, are not an automatic repetition of infantile modes in an adult setting. They are forms of behavior motivated by a desire to escape helplessness, to gratify vital needs, and to allay tension, anxiety, and hostility. The individual reacts to the present with characterologic machinery that is rooted in his past experiences, but his present day problems are the immediate result of conflicts deriving from demands, fears, and resentments that arise from his current interpersonal relationships.

(111, p. 243)

However, Wolberg is careful to point out that complete elimination of consideration of the past is equally fallacious. Palliative psychotherapy operates on such a principle while hypnoanalysis attempts to steer a middle course, or rather to make more effective use of knowledge of the past.

The major difference between hypnoanalysis and standard psychoanalysis, then, lies in the stress that is



placed on the present rather than the past, on the positive rather than the negative aspects of treatment, on ego strengthening rather than ego dissecting, and on synthesis or reintegration of personality rather than on analysis. The startling thing about all this from the viewpoint of the history of the divergent schools of psychoanalysis (such as those represented by Rank, Adler, and Horney) is that it represents an acknowledgment of some of the most significant views of these schools which historically constituted the major points of contention. This is not to say that all the divergent schools had identical ideas, but that the central idea which prompted them was an emphasis on the present, on the positive and on the synthetic rather than on the analytic.

The value of hypnoanalysis like that of the modified therapy described by the Chicago group is that it takes account of much that is valid in the divergent schools of psychoanalysis. It is well to note with Wolberg, however, that it is too recent a development on which to pass complete judgment, because many changes in theory and practice are anticipated. With admirable modesty, Wolberg states:

Hypnoanalysis is no cure-all. It has definite values but it will not move mountains. Failures occur with hypnoanalysis as they do with any other psychotherapeutic method. It is essential to stress this repeatedly, because several observers in their enthusiasm over certain effects of hypnosis on the psyche have

credited it with powers it does not possess. Whether we like it or not, there are a number of emotional conditions so malignant that they cannot be influenced readily by any known form of therapy. (111, p. xvii)

It may be added that one of the difficulties or disadvantages in hypnoanalysis is that there are many pitfalls and dangers involved in the process which require great skill to avoid. Wolberg emphasizes this throughout his book either directly or by implication, but he fails to note that this tends to place hypnoanalysis in the same light as psychoanalysis with respect to the dangers involved and the great skill that is required. If this be so, it is rather unfortunate because hypnoanalysis, as Wolberg himself points out, is partly intended as an answer to the objection raised against psychoanalysis concerning the dangers involved and the great skill required.

##### 5. Horney's "New Ways" in Psychoanalysis

Karen Horney (112) is an analyst whose objections to orthodox views led her to found a new school. Many of her objections are on a theoretical or doctrinal level, a level which is outside of the scope of the present discussion, but despite the fact that it is valid and valuable to distinguish between the various phases of psychoanalysis it still remains true that therapy is guided by theories and doctrines. It is therefore not surprising to find

that Horney's objections to Freud's theories led her to revise therapeutic principles and methods.

The revisions in therapy which Horney advocates are strikingly similar to those which characterize the modified therapy of the Chicago Institute. Certain of Freud's basic premises are accepted by both, the most important of which is stated by Horney as follows:

. . . that psychic processes are strictly determined, that actions and feelings may be determined by unconscious motivations and that the motivations driving us are emotional forces. (112, p. 18)

These premises are summed up in the concept of psychodynamics referred to by the Chicago group and in their statement to the effect that psychoanalytic therapy whether standard or brief is etiological therapy.

Horney parts with Freud on the grounds of what she characterizes as his biological orientation. She writes:

The influence of Freud's biological orientation is threefold: it is apparent in his tendency to regard psychic manifestations as the result of chemical-physiological forces; in his tendency to regard experiences and the sequence of their occurrence as determined primarily by constitutional or hereditary factors; finally, in his tendency to explain psychic differences between the two sexes as the result of anatomical differences. (112, p. 38)

Stated somewhat differently, she rejects what she terms three unwarranted assumptions made by Freud. These

are:

. . . that an inherited set of reactions is more important than the influence of the environment; that the influential experiences are sexual in nature; that late experiences to a large extent represent a repetition of those had in childhood. (112, p. 33)

In short, Horney in rejecting Freud's biological orientation is critical of his lack of cultural orientation and his insufficient recognition of cultural and environmental forces. She believes, further, that Freud operated in terms of "mechanistic evolutionary thinking" or on the assumption that:

. . . present manifestations not only are conditioned by the past, but contain nothing except the past; nothing really new is created in the process of development; what we see today is only the old in changed form. (112, p. 42)

She states further:

Freud is evolutionistic in his thinking, but in a mechanistic way. In a schematized form, his assumption is that nothing much new happens in our development after the age of five, and that later reactions or experiences are to be considered as a repetition of past ones. (112, p. 44)

Though Horney is cognizant of the fact that Freud did take account of cultural factors, she believes he did so in a limited, one-sided manner. Freud's interest was limited to discovering how culture influenced

instinctual drives and thereby frustrated the individual. She believes her own views are more complete and more dynamic in that they express an interest in the whole dynamic structure of culture in relation to personality growth. Her view involves an interest in the problems of cooperation and competition and a thorough analysis of a given culture with respect to such questions as:

In what ways and to what extent are interpersonal hostilities created in a given culture? How great is the personal security of the individual and what factors contribute toward making him insecure? What factors impair the individuals inherent self-confidence? What social prohibitions and taboos exist and what is their influence in bringing about inhibitions and fears? What ideologies are effective and what goals or rationalizations do they provide? What needs and striving are created, encouraged, or discouraged by the given conditions? (112, p. 177)

Horney's therapy may be likened to the modified therapy of the Chicago Institute in that it is particularly concerned with cases in Group III in the diagram on page 219. She would probably differ, however, from the Chicago view in that she rejects standard analysis for all types of patients. At any rate, she rejects the orthodox therapeutic principle of seeking to establish a causal connection between early childhood experiences and present difficulties. In contrast to the old view, she directs her therapy at understanding present neurotic trends in terms of their function and consequences in the present

life situation. The interpretations she makes to her patients are in accordance with her own theoretical position with regard to the origins of neuroses and maladjustments, rather than in terms of Freudian ideas about infantile traumatic experiences.

On the issue of activity versus passivity in therapy, (that is, whether the therapist assumes an active, directive role, or a passive one, thereby allowing the patient an active role) she rejects the Freudian ideal of complete passivity on the part of the therapist as one which cannot be attained. She believes the analyst should "deliberately conduct the analysis," but she says that this statement must be taken with a grain of salt "because it is always the patient who indicates the general line by showing, through his associations, the problems which are uppermost in his mind." (112, p. 287) However, she believes in active interference when the patient seems to be heading into a blind alley. Her views on the activity-passivity issue thus seem almost identical with those of the Chicago Institute who speak of rejecting the formerly accepted Freudian motto "As little interference in the patient's daily life as possible" in favor of actively influencing the course of the patient's life.

Much more could be said in the present study about the issue of activity versus passivity because it is an issue that has been confused and confusing in many



ways to all who attempt to evaluate the various schools of therapy. For the moment, let it be noted that Horney regards the use of her various techniques to reinforce or mobilize the constructive forces in the personality as active rather than passive therapy, whereas from another point of view, namely the Rankian, this amounts to passive therapy since the active, positive, will to change is encouraged. Horney, however, explicitly rejects Rank's doctrine of will power as being "too formalistic" a principle on which to base therapy. She also rejects the Rankian notion that the positive forces of will and growth can be developed without the use of direct interpretation and analysis.

#### 6. Nondirective or Client-Centered Psychotherapy

Carl R. Rogers of the University of Chicago is responsible for the recent development of the divergent school of psychoanalysis known variously as nondirective or client-centered psychotherapy, or counseling. The work of Rogers and his students is particularly significant for many reasons: (1) It has aroused a great deal of attention and has received enthusiastic reception in many quarters, especially among clinical psychologists who are interested primarily in the therapeutic aspects of clinical psychology rather than in the diagnostic. (2) The type of procedure advocated by Rogers is exceptionally well suited for

clinical psychology because it is more specifically designed to meet the needs of patients in Group III (page 219) than any other divergent school. Moreover, even within this group which includes the relatively milder cases, the nondirective therapy is particularly designed for treating the mildest cases, and consequently is well suited for clinical psychology. (3) Nondirective therapy has been conceived by a non-medically but psychologically trained person and by virtue of the theoretical formulations and clinical techniques which distinctly characterize it, nondirective therapy involves a minimum amount of danger to the patient from a medical viewpoint.

The first large scale systematic presentation of nondirective therapy appeared in 1942 with the publication of Rogers' book (46). In this book he acknowledges the fact that his concepts are related to psychoanalysis and to some of the earlier divergent schools. He writes:

These newer concepts (of non-directive therapy) have their roots in many diverse sources. It would be difficult to name them all. The thinking of Otto Rank, as it has been modified by such individuals as Taft, Allen, Robinson, and other workers into "relationship therapy" is one important point of origin. Modern Freudian analysis, which has at least become sufficiently secure to criticize Freud's therapeutic procedures and to improve upon them, is another source. Many individuals have played a part in this, of whom Horney is perhaps the best known . . .

(46, p. 27)

At a very recent date, Rogers (113) notes that the modified psychoanalytic therapy described by Alexander and French (107) is very close "and far more nearly in line" with nondirective therapy than the former views and practices of psychoanalysis, though he does point out some important differences which still remain, and which will be discussed below. It is first necessary to note that the major point of departure from orthodox psychoanalysis that characterizes nondirective therapy proceeds along the lines advocated by Rank and by his students at the Pennsylvania School of Social Work in Philadelphia.

In view of this fact it should prove interesting to note briefly some of the ideas on social case work as developed by the Pennsylvania School which are opposed to the ideas of other schools of social work that follow Freudian psychoanalysis. Pennsylvania case work is characterized as "functional case work" to refer to the stress that is placed on viewing case work as a dynamic process in which the client-worker-agency relationships are the central concern. Every person and every agency involved in the case work process are regarded as interrelated and interdependent and as serving a particular vital function in therapy. Functional case work is further characterized by the fact that it is admittedly limited to certain types of clients; to

relatively intelligent people who are mildly maladjusted.

One of the major marks of distinction of functional case work that is particularly novel to the psychologist is its lack of interest in diagnosis in the usual sense of the term. Diagnosis is regarded as antagonistic to functional case work because it interferes with the process of offering help and this process is the vital part of case work. J. Taft (114) writes of diagnosis as follows:

We understand diagnosis, then, not as a categorizing of the client's make-up, with a resultant prescription for his needs, from the viewpoint of an adjusted personality, but an attempt on the part of worker and client to discover whether client need and agency service can be brought into a working connection that is mutually acceptable. The diagnosis is made when the worker and client arrive at a plan for continuing or finally terminating the contact. Diagnosis in this view leads not to treatment but to a working relationship, set up under certain determining conditions, with a purpose or plan worked out by the client and accepted as a tentative arrangement by agency. There is here no secret labeling of the personality of the client by the worker, no unshared intention to treat "a fundamental emotional problem," but a practical judgment reached through an application process in which the client has an equal responsibility. The worker carries full responsibility for agency service, for the knowledge of the problems this very service can create for the client and his family, for understanding the universal human resistance to being helped, no matter how great the need, and for the skillful utilization of time in the client's interest. But no worker knows, or should presume to try to control, the vital

process through which the client experiences change in his use of agency. Nor can any worker, however skillful, determine or foresee the exact nature, direction, and depth of such change. Herein lies the freedom for creative utilization of help that escapes the foreknowledge or diagnostic acumen of the helper, however scientific his attitude, and goes beyond or even against any treatment plan laid down in advance.

(114, p. 8)

Functional case work, then, is actually not treatment or psychotherapy in the strict sense of implying that the therapist makes a diagnosis and formulates a plan of treatment on the basis of that diagnosis, and in which the therapist assumes the responsibility of directing the treatment. It is nondirective therapy in its most radical form, and consequently it is not surprising to find Rogers (46, pp. 249-252) thinking of diagnosis in much the same terms. It is perhaps part of the reason why Rogers prefers the term counseling rather than psychotherapy though he uses both terms interchangeably.

Another difference between functional case work and psychotherapy, strictly or traditionally conceived, is that which arises out of the fact that case work limits its role to the immediate situation and to dealing effectively with personality change only as it is related to the immediate situation, while psychotherapy attempts to effect deep and widespread changes in personality.

This difference is not as sharp in the case of the modified psychotherapy of the Chicago group or of any modified psychotherapy as it is in respect to psychoanalysis.

The essential characteristics which are basic to functional case work and to Rogers's nondirective psychotherapy may now be noted: (1) The stress is placed on the ego or the conscious aspects of personality rather than on the unconscious as in psychoanalysis and to some though in a lesser extent the psychoanalytic therapy of the Chicago group, in hypnoanalysis, and in the therapy of Horney. (2) The stress is placed on the conviction that almost all individuals have a capacity for growth and development. (3) The primary role of the case worker or therapist is to assist the client in the discovery of his own individual capacity for growth and to offer support, reassurance, and encouragement to the client in order to help him proceed in a positive direction.

Great skill is required to accomplish the objectives of functional case work and of nondirective therapy. The therapist is required to act as a mirror wherein the client can see himself as he struggles through the task of discovering his strengths and as he slowly learns how to use them. Grace Marcus (114) describes the skills involved in the process as follows:

There can be no doubt that the way traveled by client and case worker is



the hard way, through the midst of the pains and struggle which the human ego so frequently tries to escape, in the false and neurotic solution of self compromise. The ego naturally shrinks from the difficult choice, and many of the choices open to clients are between one harsh external compulsion and another. To meet these compulsions may exact of the client changes that penetrate deeply into his habits of feeling and acting, or that call for assertions of himself that he has previously dodged, or demand that he measure some new independence against the effort that he himself must make to gain it. (114, p. 159)

The therapist must be completely aware of all that happens in the therapy session; he must know and understand the feelings and attitudes of the client. He must create a permissive atmosphere in which the client will feel free to express his feelings and ideas. The significant skills, however, are those required in the process of revealing, clarifying, and evaluating the client's feelings and ideas in a way which does not involve direct analysis and interpretation and yet permits the client to achieve insight and to change his behavior in positive directions consistent with his own personality and life situation. Skills are also necessary in the problem of deciding when this particular type of therapy is indicated and when it is contra-indicated, for it is clearly recognized that this type of therapy can be successful only with a certain type of case.

The interesting question as to whether there are essential differences between modified psychoanalytic

therapy as developed by the Chicago Institute and non-directive therapy may now be raised. It has already been indicated that a good deal of the modification that appears in the Chicago Institute therapy actually represents an acceptance of the divergent views upon which nondirective therapy is founded. Moreover, Rogers himself was quoted as recognizing the similarity between his ideas and those of Alexander and French. Now it remains to be noted that Rogers nevertheless thinks of nondirective therapy as being very different from that advocated by Alexander and French for several reasons. He believes that Alexander and French have not fully accepted the principle of allowing the client a maximum amount of responsibility and freedom to work out his own problems at his own pace in accordance with his specific needs and capacities for growth. In other words, Rogers believes they have not fully accepted the basic principle of nondirection, nondomination and noncontrol of the therapeutic process by the therapist. The client-centered therapist, on the other hand, Rogers states:

. . . has learned that the constructive forces in the individual can be trusted, and the more deeply they are relied upon, the more deeply they are released. He (the therapist) has come to build his procedures upon these hypotheses, which are rapidly becoming established as facts; that the client knows the areas of concern which he is ready to explore; that the client is the best judge as to the most desirable frequency of interviews; that the client can lead the way

more efficiently than the therapist into deeper concerns; that the client will protect himself from panic by ceasing to explore an area which is becoming too painful; that the client can and will uncover all the repressed elements which it is necessary to uncover in order to build a comfortable adjustment; that the client can achieve for himself far truer and more sensitive and accurate insights than can possibly be given to him; that the client is capable of translating these insights into constructive behavior which weighs his own needs and desires realistically against the demands of society; that the client knows when therapy is completed and he is ready to cope with life independently. Only one condition is necessary for all these forces to be released, and that is the proper psychological atmosphere between client and therapist. (113, p. 419)

This question of difference can probably only be settled in terms of an answer to another question that should be raised as to the actual degree of nondirectiveness it is possible to achieve. It seems probable that Rogers tends to overestimate this. It is almost inevitable, as was pointed out in Chapter IV, that the therapist will arrive at some interpretation of the behavior of the client and that he will indicate or reveal the nature of that interpretation to the client in some manner however subtly or unwittingly. The therapist, moreover, is bound to express approval or disapproval of the feelings, attitudes and behavior of the client even though very indirectly, for what other way can the therapist help the client to

gain insight into the realities of his maladjustment and the realities of his life situation? Therapy is carried out within an ethical frame of reference, whether it be consciously formulated or not, and consequently value judgments are involved and direction is indicated.

Does this mean, then, that there are no differences between directive and nondirective therapies? This does not follow because the basic differences which arise out of the amount of freedom and responsibility given the client, the amount of confidence that is placed in the capacity for growth, and the amount of stress on the present conscious problems still remain. The basic differences are those which may best be described in terms of an authoritarian versus a democratic philosophy but it must be realized that the latter does not require the abandonment of giving direction. Direction may be given in a democratic manner and in respect to democratic goals which are largely chosen by the individual and are in accord with his personality. Indeed, it must be given in most cases if those goals are to be achieved efficiently.

The important finding of the present study on the question of differences between nondirective therapy and the other modified psychoanalytic therapies discussed is that they are probably less sharp than would appear on the surface, or from the statements of the leaders of the various schools. In other words, nondirective therapy is

not as thoroughly nondirective as it claimed to be, while directive therapy has assumed the character of nondirective therapy in many important respects.

### 7. The Meaning of Psychotherapy from the Viewpoint of Clinical Psychology

The theory and practice of psychotherapy is unsystematic almost to the point of presenting a very confusing picture. There are innumerable theories, methods, and techniques some of which appear as part of an organized though limited systematic framework, while others are more or less haphazardly formulated. From the viewpoint of clinical psychology as a systematic discipline, it is necessary to analyze the various conflicting theories in order to discover and evaluate the ideas that may be common to them all as well as those which are complementary and/or supplementary. This is a preliminary step to arriving at a systematic theory or at least a systematic viewpoint with regard to the problem of psychotherapy. Research methods may then be employed to test out hypotheses and to validate principles and methods.

For the present, the meaning of psychotherapy can be formulated as follows: Psychotherapy of any kind involves changing human behavior in some way and to some degree. It is concerned with all aspects of personality since they all may be involved in the changes taking place

but the emotional, and attitudinal aspects of personality are usually of the greatest concern. The process of change may be understood as a re-learning or re-education process provided these terms are applicable to the emotional aspects of personality.

The notion of change or re-education presupposes that there exists a need for change so it may be said that all psychotherapy proceeds on the assumption that personality of a given individual is maladjusted to some degree; that the individual is not functioning well either with respect to his own needs or those of society or both.

The maladjustment may or may not be extremely severe to the point of causing great suffering to the individual and/or those about him, and it may or may not pervade the physical aspects of personality producing psychosomatic symptoms. Consequently, the changes to be effected may or may not need to be radical; they may or may not involve deep layers of the personality and may or may not also require physical treatment measures.

The notion of changing personality besides assuming the need for change also implies that the change will take place in some direction and toward some goal.

All psychotherapy aims at the adjustment of the individual but actually there exists a variety of possible answers to the question of what constitutes adjustment and as to the more specific goals of therapy. The specific goal may



be achievement of insight into unconscious motivations and a thorough understanding of the self, it may be the achievement of only partial insight and understanding, it may be more superficial and merely supportive as distinct from uncovering, or, it may be unfixed in the sense of being bounded only by the unforeseen limits of the growth of a given personality.

The choice of the goal involves a choice of technique. To a certain extent this becomes an ethical question since it means a choice of basic values, but it also is a methodological and psychological question since it involves the choice of one theory over another. There are other variables to be considered, however, such as the type of case (severe or mild, intelligent or not, young or old), and the circumstances in the life of the client.

Diagnosis of a general nature is always involved in psychotherapy; the decision to embark on any form of psychotherapy must be made, for psychotherapy may be contra-indicated in certain types of cases, or a particular form of psychotherapy may be contra-indicated. While it may be true that nondirective therapy need not start with specific diagnosis, it must use a general form of diagnosis in making the decision to accept or reject a client for treatment. Moreover, from the standpoint of clinical psychology no particular type of therapy is applicable to

all of the types of cases so diagnosis must be employed to decide which, if any, type of therapy should be used.

It should be emphasized that from the standpoint of clinical psychology the practice of psychotherapy should be limited to those cases in Group III in the diagram on page 219, but even then psychotherapy should never be the full responsibility of clinical psychology. Since psychotherapy deals with the whole personality, it is best practiced in a clinical team setting. It is true that in the past the use of the clinical team principle often had the effect of defining clinical psychology in terms of psychometrics or diagnosis, but the clinical team principle need not be interpreted in such a narrow way.

With regard to the question of age level, there has been a definite tendency for clinical psychology to limit the practice of therapy to the younger age groups. This probably arises out of the close connection between psychology and education and out of other reasons connected with the history of clinical psychology, but there does not seem to be any intrinsic reason for imposing any age-level limitations. It is a fact, however, that by virtue of his training the psychologist is likely to know more about children than about adults and so is more effective in treating children.

Psychotherapy of any kind involves the establishment of a personal relationship between client and therapist. The type of relationship may vary in many respects; it may be extremely intense as in standard psychoanalysis where "transference" takes place, it may be very mild as in the case of palliative therapy, it may be authoritarian or directive, it may be warm and permissive, it may be consciously recognized and employed in a controlled manner to effect therapeutic changes, or it may be only vaguely recognized and haphazardly employed. The significant fact is that psychotherapy always takes place within some type of personal relationship which from the standpoint of a systematic and rational clinical psychology means that the nature of this relationship should be known and understood as fully as possible. This is a requirement not only from the point of view of clinical psychology as a systematic discipline but also from the point of view of ethics.

## CONCLUDING STATEMENT

The term "clinical psychology" has many meanings and its use involves many controversial problems and issues which occur in various frames of reference and at various levels of discourse. This study has dwelt upon a number of these problems and issues in an effort to call attention to them, to clarify them, and to evaluate them critically wherever this seemed possible. The main objective, however, was to relate these problems to the task of understanding the meaning of clinical psychology as an organized discipline.

The attempt to inquire into so many problems and issues, has turned out to be one of the major limitations of the study in that no single problem could be treated with the thoroughness demanded by its subject matter. Yet, the present inquiry is not without virtue in that there has been little conscious recognition that clinical psychology actually involves so many diverse problems and issues, the ramifications of which are so wide, and which demand clarification and evaluation if clinical psychology is ever to become a systematic discipline.

Since the emphasis has been deliberately on the controversial, little attention was given to formulating any final conclusions. Certain tentative conclusions, however, were indicated in the course of the discussion,

but need not be repeated here. The main findings from the point of view of the entire study may now be summarized:

(1) The problem of defining clinical psychology is complicated to a tremendous degree by the fact that it is practiced in many diverse situations and circumstances. These areas are not particularly well delineated but in general they may be described as, (a) the military, (b) the institutional-public and private hospitals of all types, educational institutions, penal institutions of all types, (c) welfare agencies of various types including those set up to handle Veteran Rehabilitation, (d) industrial, (e) private consultation.

(2) The practice of clinical psychology in these areas is extremely difficult to describe primarily because of the lack of uniformity of major aims and objectives, and of the main techniques required. This is partly a result of the particular type of situation, and also a consequence of the historical development of clinical psychology. At any rate, three major levels of performance can be distinguished: the purely psychometric (mechanical administration of tests); the diagnostic (the use of tests in a clinical manner, skillfully and flexibly, as a method of standardizing the interview situation); and the primarily therapeutic.

(3) The aims and objectives of performance on the separate levels, especially the first two, are limited from the standpoint of the amount of attention given to the individual and the quality of the services rendered the individual. On the psychometric level, relatively little attention is given to the individual; he is simply compared to a norm with respect to some trait or ability. Little service is rendered to him from his own point of view; the test is usually given from the point of view of the efficiency or the welfare of the group of which he happens to be a member or perhaps wishes to become a member. On the diagnostic level, the individual is given a good deal of attention; he is not only compared to norms but his whole personality configuration is taken into consideration. Little service is rendered him directly, however, though the diagnosis may ultimately be used for his welfare. On the therapeutic level, much attention is given the individual and direct service in his welfare is given him though conceivably some forms of therapy may be administered which would not be primarily in the interest of the client.

(4) Clinical psychology, as a complete discipline insofar as it is primarily concerned with the individual and in giving service for the welfare of the individual, must perform at both the diagnostic and therapeutic levels.



Division of labor for administrative reasons, or for reasons related to standards and training, or any special reasons of circumstance may be warranted but this must be accomplished self-consciously. The primary purposes and concerns of clinical psychology cannot be lost from view without creating a hopelessly confused situation.

(5) The problem of defining clinical psychology is further complicated by the fact that it is at once a science and an applied science in one aspect, an art in another, and a profession in another aspect. It is a science in so far as it represents a body of knowledge and is concerned with discovering further knowledge. The concept of science itself has several meanings, however, and so the problem arises of deciding which is more appropriate to the particular activities and subject matter of clinical psychology.

(6) The fact that clinical psychology is concerned with human behavior in all its complexity and variability, and the further fact that it is concerned with individual human behavior raises the question of whether science can be defined broadly enough (without losing its meaning) to be an appropriate conceptual framework for formulating the theories and methods of clinical psychology. The controversy centered around the definition of clinical psychology as an art arises out of

these facts and difficulties.

(7) The concept of art has other meanings, some of which seem related to the distinction between pure and applied science, and others which seem of a negative quality. In this latter case, it is understood as something which is poor science or an unfortunate though perhaps necessary stage in the development of science.

(8) Most modern psychologists attempt to include all of clinical psychology as part of science and in doing so must redefine science to take account of the particular kind of data presented in clinical psychology. G. W. Allport is an outstanding psychologist who makes such an attempt. His position as well as some opposing positions are described in detail.

(9) The fact that the concern of clinical psychology is with the welfare of individual behavior in relation to society serves to control the definition of clinical psychology as a profession. More specifically, this means that clinical psychology as a profession involves the following responsibilities: (a) to the individual client or patient, (b) to the groups within which he lives and to society at large, (c) to the profession itself and to other professions. These

responsibilities must be implemented by further considerations of standards of achievement and competence, standards of training, and of certification and licensing. These considerations, however, can have meaning only in terms of the major responsibilities. Moreover, they presuppose the solution of the problems of defining clinical psychology as a science and as an art.

(10) Several statements can be made about psychotherapy as a part of clinical psychology from the viewpoint of the entire study. Psychotherapy is probably growing in significance as a legitimate function of clinical psychology. Without this growth clinical psychology can never become a completely organized discipline in the sense of being systematically concerned with the welfare of the individual in society. Clinical psychology defined only in terms of psychometry or diagnostics becomes a subsidiary discipline to general psychology, medicine or to education. The problem of developing psychotherapy as part of clinical psychology is complicated by these facts: (a) relatively little is known in this area, (b) much that is known is traditionally or conventionally a part of medicine (psychiatry), (c) and a good deal must always remain conventionally part of medicine.

Clinical psychology is a science (pure and applied), an art and a profession. It is primarily

concerned with understanding, predicting and controlling individual human behavior; with diagnosis and treatment. From the point of view of the conventional sciences and disciplines, it is a composite of many of them, but it could be systematically clarified from the standpoint of its major concerns and in terms of its use of the various forms of discourse or knowledge used by Man to understand, predict and control experience.

## BIBLIOGRAPHY

1. Griffith, Coleman R., PRINCIPLES OF SYSTEMATIC PSYCHOLOGY, University of Illinois Press, Urbana, Illinois.
2. Editors, "The Field of Clinical Psychology, Past, Present and Future," JOURNAL OF CLINICAL PSYCHOLOGY, January, 1945, pp. 1-20.
3. Robinson, Virginia P., A CHANGING PSYCHOLOGY IN SOCIAL CASE WORK, The University of North Carolina Press, Chapel Hill, 1934.
4. JOURNAL OF CONSULTING PSYCHOLOGY (cover), 1937.
5. HEARINGS BEFORE A SUBCOMMITTEE OF THE COMMITTEE ON EDUCATION AND LABOR, U. S. Senate, 79th Congress, 2nd Session On S. 1160, U.S. Government Printing Office, Washington, 1946.
6. "Editorial," JOURNAL OF CLINICAL PSYCHOLOGY, 1946, pp. 396-400.
7. Darley, John G. and Berdie, Ralph, "The Fields of Applied Psychology, A Survey Report to the Committee on Professional Employment of the American Association for Applied Psychology," JOURNAL OF CONSULTING PSYCHOLOGY, 1940, pp. 41-52.
8. Allport, Gordon W., "The Psychologist's Frame of Reference," PSYCHOLOGICAL BULLETIN, 1940, pp. 1-28.
9. Hilgard, Ernest R., "Psychologist's Preferences for Divisions under the Proposed A.P.A. By-Laws," PSYCHOLOGICAL BULLETIN, 1945, pp. 20-26.
10. Brotemarkle, R. A., "The Challenge to Consulting Psychology," JOURNAL OF APPLIED PSYCHOLOGY, 1940, pp. 10-19.
11. Steiner, Lee R., WHERE DO PEOPLE TAKE THEIR TROUBLES, Houghton Mifflin Co., Boston, 1945.
12. Stern, William, GENERAL PSYCHOLOGY FROM THE PERSONALISTIC STANDPOINT (Translated by Howard Davis Spoerl), The Macmillan Company, New York, 1938.

13. Seashore, Carl E., "Pioneering in Psychology," UNIVERSITY OF IOWA STUDIES, No. 398, University of Iowa Press, Iowa City, Iowa, 1942.
14. "Activities of Clinical Psychologists," PSYCHOLOGICAL BULLETIN, 1917, pp. 224-225.
15. Franz, S. I., "Psychology and Psychiatry," PSYCHOLOGICAL BULLETIN, 1917, pp. 226-229.
16. Babcock, Harriet, "The Error in Psychiatry," JOURNAL OF CLINICAL PSYCHOLOGY, 1945, pp. 253-261.
17. Seidenfeld, Morton A., "Error Redundant: A Reply to 'The Error in Psychiatry,'" JOURNAL OF CLINICAL PSYCHOLOGY, 1946, pp. 191-194.
18. Ives, Margaret, "Interrelationship of Clinical Psychology and Psychiatry," JOURNAL OF CLINICAL PSYCHOLOGY, 1946, pp. 146-150.
19. Zilboorg, Gregory, MIND, MEDICINE, & MAN, Harcourt, Brace and Company, New York, 1943.
20. Yerkes, Robert M. Major, "Report of the Psychology Committee of the National Research Council," THE PSYCHOLOGICAL REVIEW, 1919, pp. 83-149.
21. Yerkes, Robert M. (Editor), "Psychological Examining in the United States Army," MEMOIRS OF THE NATIONAL ACADEMY OF SCIENCES, Vol. 15, Washington, Government Printing Office, 1921.
22. Yerkes, Robert M., "Manpower and Military Effectiveness: The Case for Human Engineering," JOURNAL OF CONSULTING PSYCHOLOGY, 1941, pp. 205-209.
23. Harrell, T. W. and Churchill, Ruth D., "The Classification of Military Personnel," PSYCHOLOGICAL BULLETIN, 1941, pp. 331-353.
24. Staff; Personnel Research Section, Classification and Replacement Branch, Adjutant General's Office, "Some Aspects of the Relationship Between Personnel Research and Clinical Psychology in the Army," JOURNAL OF CLINICAL PSYCHOLOGY, 1945, pp. 105-112.
25. Seidenfeld, Morton A., "Psychological Services for the Individual in the Armed Forces," JOURNAL OF CLINICAL PSYCHOLOGY, 1945, pp. 93-98.



26. Sears, Robert R., "Clinical Psychology in the Military Services," PSYCHOLOGICAL BULLETIN, 1944, pp. 502-509.
27. Sears, Robert R. (Editor), "Clinical Psychology in the Military Services," PSYCHOLOGICAL BULLETIN, 1944, pp. 502-579.
28. Krugman, Morris, "Recent Developments in Clinical Psychology," JOURNAL OF CONSULTING PSYCHOLOGY, 1944, pp. 342-352.
29. Hunt, William A. and Stevenson, I., "Psychological Testing in Military Clinical Psychology: I, Intelligence Testing," PSYCHOLOGICAL REVIEW, 1946, pp. 28-35.
30. Hunt, William A. and Stevenson, I., "Psychological Testing in Military Clinical Psychology: II, Personality Testing," PSYCHOLOGICAL REVIEW, 1946, pp. 107-115.
31. Tibbitts, Clark (Co-Editor), "Symposium: Clinical Psychology in the Civilian Rehabilitation Services," JOURNAL OF CLINICAL PSYCHOLOGY, 1946, pp. 105-145.
32. "Symposium: The Veterans Administration and Clinical Psychology," JOURNAL OF CLINICAL PSYCHOLOGY, 1947, pp. 1-56.
33. Campbell, Helen W., "The Role of the Clinical Psychologist in a Veterans Administration Mental Hygiene Clinic," JOURNAL OF CLINICAL PSYCHOLOGY, 1947, pp. 15-21.
34. Wells, F. L. et al, "Psychologists' Functions in Hospitals," JOURNAL OF CONSULTING PSYCHOLOGY, 1944, pp. 267-322.
35. Shakow, David, "The Functions of the Psychologist in the State Hospital," JOURNAL OF CONSULTING PSYCHOLOGY, 1939, pp. 20-23.
36. Viteles, Morris S., "Postlude: The Past & Future of Industrial Psychology," JOURNAL OF CONSULTING PSYCHOLOGY, 1944, pp. 182-186.
37. Meltzer, H., "Approach of the Clinical Psychologist to Management Relationships," JOURNAL OF CONSULTING PSYCHOLOGY, 1944, pp. 165-174.

38. Roethlisberger, F. J. and Dickson, William J.,  
MANAGEMENT AND THE WORKER, Harvard Uni-  
versity Press, Cambridge, Massachusetts,  
1939.
39. Cantor, Nathaniel, EMPLOYEE COUNSELING - A NEW VIEW-  
POINT IN INDUSTRIAL PSYCHOLOGY, McGraw Hill  
Book Co., Inc., 1945.
40. Garrett, Annette, COUNSELING METHODS FOR PERSONNEL  
WORKERS, Family Welfare Association of  
America, 1945.
41. Stevenson, George S. and Smith, Geddes, CHILD  
GUIDANCE CLINICS, A QUARTER CENTURY OF  
DEVELOPMENT, The Commonwealth Fund, New  
York, Oxford University Press, 1934.
42. Cook, P. H., THE THEORY AND TECHNIQUE OF CHILD  
GUIDANCE, Melbourne University Press and  
Oxford University Press, 1944.
43. Witmer, Helen Leland (Editor), PSYCHIATRIC INTERVIEWS  
WITH CHILDREN, The Commonwealth Fund,  
New York, 1946.
44. Symonds, Percival M., "The School Psychologist,"  
JOURNAL OF CONSULTING PSYCHOLOGY, 1942,  
pp. 173-176.
45. Hutcherson, George E. et al New York State Counselors  
Association, PRACTICAL HANDBOOK FOR  
COUNSELORS, Science Research Associates,  
Chicago, 1946.
46. Rogers, Carl R., COUNSELING AND PSYCHOTHERAPY, NEWER  
CONCEPTS IN PRACTICE, Houghton Mifflin  
Company, 1942.
47. Lindner, Robert M. and Seliger, Robert, V., et al.  
HANDBOOK OF CORRECTIONAL PSYCHOLOGY?  
Philosophical Library, New York, 1947.
48. Moulton, Forest Ray and Schiffers, Justus J. (Editors)  
THE AUTOBIOGRAPHY OF SCIENCE, Doubleday  
and Company, Inc., Garden City, New York,  
1946.
49. Carnap, Rudolf, "Logical Foundation of the Unity of  
Science," INTERNATIONAL ENCYCLOPEDIA OF  
UNIFIED SCIENCE, Vol. 1, Number 1, 1938,  
The University of Chicago Press, Chicago,  
Illinois.

50. Wheeler, R. H., THE SCIENCE OF PSYCHOLOGY, Revised Edition, The Thomas Y. Crowell Company, New York, 1940.
51. Dewey, John, "Unity of Science as a Social Problem," INTERNATIONAL ENCYCLOPEDIA OF UNIFIED SCIENCE, Vol. 1, Number 1, 1938, The University of Chicago Press, Chicago, Illinois.
52. Morris, Charles W., SIGNS, LANGUAGE AND BEHAVIOR, Prentice-Hall, Inc., New York, 1946.
53. Whitehead, Alfred North, SCIENCE AND THE MODERN WORLD (Lowell Lectures - 1925), The Macmillan Company, 1939.
54. Lewin, Kurt, PRINCIPLES OF TOPOLOGICAL PSYCHOLOGY, McGraw Hill Book Company, New York, 1936.
55. Hull, Clark L., PRINCIPLES OF BEHAVIOR - AN INTRODUCTION TO BEHAVIOR THEORY, D. Appleton Century Co., 1943.
56. Knight, Frank H., "Fact and Value in Social Science," in SCIENCE AND MAN, edited by Ruth Nanda Anshen, Harcourt, Brace and Company, New York, 1942.
57. Knight, Frank H., THE ETHICS OF COMPETITION AND OTHER ESSAYS, George Allen and Unwin Ltd., London, England, 1935.
58. Neurath, Otto, "Foundations of the Social Sciences," INTERNATIONAL ENCYCLOPEDIA OF UNIFIED SCIENCES, Vol. 11, Number 1, The University of Chicago Press, Chicago, Illinois, 1944.
59. Donham, Wallace Brett, EDUCATION FOR RESPONSIBLE LIVING, THE OPPORTUNITY FOR LIBERAL ARTS COLLEGES, Harvard University Press, Cambridge, Massachusetts, 1945.
60. Hook, Sidney, REASON, SOCIAL MYTH AND DEMOCRACY, The John Day Company, New York, 1940.
61. Crowther, J. G., THE SOCIAL RELATIONS OF SCIENCE, Macmillan Company, New York, 1941.
62. Murphy, Gardner, "The Freeing of Intelligence," PSYCHOLOGICAL BULLETIN, 1945, pp. 1-19.

63. Miller, James Grier, UNCONSCIOUSNESS, John Wiley & Sons, Inc., New York, 1942.
64. Allport, Gordon W., THE USE OF PERSONAL DOCUMENTS IN PSYCHOLOGICAL SCIENCE, Social Science Research Council, Bulletin 49, 1942, New York.
65. Sarbin, Theodore R., "The Logic of Prediction," THE PSYCHOLOGICAL REVIEW, 1944, pp. 210-228.
66. Horst, Paul, Wallin, Paul, and Guttman, Louis, THE PREDICTION OF PERSONAL ADJUSTMENT, Social Science Research Council, Bulletin 48, 1941, New York.
67. McNemar, Quinn, "Sampling in Psychological Research," THE PSYCHOLOGICAL BULLETIN, 1940, pp. 331-365.
68. Vernon, P. E., "The Stanford-Binet Test as a Psychometric Method," CHARACTER AND PERSONALITY, 1937, pp. 99-113.
69. Cattell, R. B., "Measurement Versus Intuition in Applied Psychology," CHARACTER AND PERSONALITY, 1937, pp. 114-131.
70. Thomas, F. C., "Intuition or Psychometry in the Study of Personality," CHARACTER AND PERSONALITY, 1938, pp. 309-317.
71. Zilsel, Edgar, "The Problem of Empiricism," INTERNATIONAL ENCYCLOPEDIA OF UNIFIED SCIENCE, Vol. II, Number 8, The University of Chicago Press, Chicago, Illinois.
72. Louttit, C. M., CLINICAL PSYCHOLOGY OF CHILDREN'S BEHAVIOR PROBLEMS, Revised Edition, Harper & Brothers, New York, 1947.
73. Rapaport, David, DIAGNOSTIC PSYCHOLOGICAL TESTING, THE THEORY, STATISTICAL EVALUATION, AND DIAGNOSTIC APPLICATION OF A BATTERY OF TESTS, Vol. I, The Year Book Publishers, Inc., Chicago, Illinois, 1945.
74. Sargent, Helen, "Projective Methods: Their Origins, Theory, and Application in Personality Research," PSYCHOLOGICAL BULLETIN, 1945, pp. 257-293.

75. Klopfer, Bruno, "Personality Diagnosis in Childhood," in MODERN TRENDS IN CHILD PSYCHIATRY, edited by Lewis, Nolan D. G. and Parcella, Bernard L., International Universities Press, New York, 1945.
76. Sarbin, Theodore H., "Clinical Psychology--Art or Science," PSYCHOMETRIKA, 1941, pp. 391-400.
77. Fernberger, Samuel W., "The History of the Psychological Clinic," in CLINICAL PSYCHOLOGY, STUDIES IN HONOR OF LIGHTNER WITMER, edited by Brottemarkle, Robert A., University of Pennsylvania Press, 1931.
78. Louttit, G. M., "The Nature of Clinical Psychology," PSYCHOLOGICAL BULLETIN, 1939, pp. 361-389.
79. Flugel, J. G., MAN, MORALS AND SOCIETY, A PSYCHOANALYTICAL STUDY, International University Press, New York, 1945.
80. Green, Arnold W., "Social Values and Psychotherapy," JOURNAL OF PERSONALITY, 1946, pp. 199-227.
82. Stevenson, Charles L., ETHICS AND LANGUAGE, Yale University Press, New Haven, 1944.
83. Taussch, Carl F., PROFESSIONAL AND BUSINESS ETHICS, Henry Holt and Company, New York, 1926.
84. Kohn, R. D., "The Significance of the Professional Ideal," in THE ETHICS OF THE PROFESSIONS AND OF BUSINESS, The Annals--The American Academy of Political and Social Science, Vol. C. I., May, 1922.
85. MacIver, R. M., "The Social Significance of Professional Ethics," in THE ETHICS OF THE PROFESSIONS AND OF BUSINESS, The Annals--The American Academy of Political and Social Science, Volume C. I., May, 1922.
86. Elliott, Lula J., SOCIAL WORK ETHICS, STUDIES IN THE PRACTICE OF SOCIAL WORK, American Association of Social Workers, New York, 1931.
87. Sutich, Anthony, "Toward A Professional Code for Psychological Consultants," JOURNAL OF ABNORMAL AND SOCIAL PSYCHOLOGY, 1944, pp. 329-350.

88. Sargent, Helen, "Professional Ethics and Problems of Therapy," JOURNAL OF ABNORMAL AND SOCIAL PSYCHOLOGY, 1945, pp. 47-60.
89. Berdie, R. F., "A Note on Counseling and Psychotherapy," JOURNAL OF CONSULTING PSYCHOLOGY, pp. 149-151.
90. Bixler, Ray and Seeman, Julius, "Suggestions for a Code of Ethics for Consulting Psychologists," JOURNAL OF ABNORMAL AND SOCIAL PSYCHOLOGY, 1946, pp. 486-490.
91. Vernon, W. H. D., "Some Professional Problems of the Consulting Psychologist," JOURNAL OF CONSULTING PSYCHOLOGY, 1946, pp. 136-142.
92. Heiser, Karl F., "Certification of Psychologist in Connecticut," PSYCHOLOGICAL BULLETIN, 1945, pp. 624-630.
93. Shartel, Carroll L., "Occupations in Psychology," THE AMERICAN PSYCHOLOGIST, 1946, pp. 559-582.
94. Committee of American Association for Applied Psychology, "Proposed Program of Professional Training in Clinical Psychology," JOURNAL OF CONSULTING PSYCHOLOGY, 1943, pp. 23-26.
95. American Psychological Association and American Association for Applied Psychology Committees on Graduate and Professional Training: Subcommittee Report on Graduate Internship Training in Psychology, JOURNAL OF CONSULTING PSYCHOLOGY, 1945, pp. 243-266.
96. Poffenberger, A. T., "The Training of a Clinical Psychologist," JOURNAL OF CONSULTING PSYCHOLOGY, 1938, pp. 1-6.
97. Morrow, William R., "The Development of Psychological Internship Training," JOURNAL OF CONSULTING PSYCHOLOGY, 1946, pp. 165-183.
98. Shakow, David, "The Training of the Clinical Psychologist," JOURNAL OF CONSULTING PSYCHOLOGY, 1942.
99. Rogers, Carl R., "Needed Emphases in the Training of Clinical Psychologists," JOURNAL OF CONSULTING PSYCHOLOGY, 1939, pp. 141-146.



100. Fryer, Douglas, "Applied and Professional Attitudes,"  
JOURNAL OF CONSULTING PSYCHOLOGY, 1939,  
pp. 1-10.
101. Reynolds, Bertha C., "The Development of a Professional  
Self," THE FAMILY, 1937, pp. 61-66.
102. Maslow, A. H., "The Authoritarian Character structure,"  
in TWENTIETH CENTURY PSYCHOLOGY, edited by  
Philip L. Harriman, The Philosophical  
Library, 1946.
103. Report of the Committee on the American Board of  
Examiners in Professional Psychology, in  
"Proceedings of the Fifty-Fourth Annual  
Meeting of the American Psychological  
Association," THE AMERICAN PSYCHOLOGIST,  
1946, pp. 493-532.
104. Glueck, Bernard (editor), CURRENT THERAPIES OF  
PERSONALITY DISORDERS, Grune and Stratton,  
New York, 1946.
105. Masserman, Jules H., PRINCIPLES OF DYNAMIC PSYCHIATRY  
INCLUDING AN INTERGRATIVE APPROACH TO  
ABNORMAL AND CLINICAL PSYCHOLOGY, W. B.  
Saunders Company, 1946.
106. Gregg, Alan, "What is Psychiatry," BULLETIN OF THE  
MENNINGER CLINIC, Vol. 6, No. 5, 1942.
107. Alexander, Franz, and French, Thomas M., et al,  
PSYCHOANALYTIC THERAPY, The Ronald Press  
Company, New York, 1946.
108. Brown, J. F., THE PSYCHODYNAMICS OF ABNORMAL BEHAVIOR,  
McGraw-Hill Book Company, New York, 1940.
109. Dalbiez, Roland, PSYCHOANALYTICAL METHOD AND THE  
DOCTRINE OF FREUD, Vol. I, EXPOSITION,  
Vol. II, DISCUSSION, translated by T. F.  
Lindsay, Longmans, Green and Company, 1941.
110. Landis, Garney, "Psychoanalysis and Scientific Method,"  
PROCEEDINGS OF THE AMERICAN PHILOSOPHICAL  
SOCIETY, 1941, pp. 515-526.
111. Wolberg, Lewis R., HYPNOANALYSIS, Grune and Stratton,  
New York, 1945.

112. Horney, Karen, NEW WAYS IN PSYCHOANALYSIS, W. W. Norton and Company, New York, 1939.
113. Rogers, Carl R., "Significant Aspects of Client-Centered Therapy," THE AMERICAN PSYCHOLOGIST, 1946, pp. 415-422.
114. Taft, Jessie (Editor), A FUNCTIONAL APPROACH TO FAMILY CASE WORK, University of Pennsylvania Press, Philadelphia, 1944.